| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1'' | IPLE CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|--|--|---------------------|---|--|----------------------------|
| _ 4 | | 495246 | B. WING | | C 02/07/2019 | |
| 101 | ROVIDER OR SUPPLIER | At the continue of the continu | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY) | D BE | (XS) COMPLETION DATE |
| | ordered. 5. The facility staff fai Resident #1's care pl administration. 6. The facility staff fa Resident # 309's care physician's order to do The findings include: 1. The facility staff fa Resident #39's complete reviewed and/or revision 12/24/18, 1/1/19, 1/6/ Resident #39 was mone facility on 12/6/18 with limited to dementia, do high blood pressure, and osteoarth (Minimum Data Set) with an ARD (Assess 12/3/18. The resident moderately impaired in decisions. The resident moderately impaired in decisions. The resident extensive care for battle eating; and supervision dressing, and transfers. A review of the nurse's 11/8/18, which docume condition has been no include: Falls 11/8/18 | led to review and revise an to include oxygen iled to review and/or revise a plan to reflect the iscontinue a Foley catheter. iled to evidence that rehensive care plan was ed after a fall on 11/8/18, 19, and 2/3/19. st recently readmitted to the othe diagnoses of but not isbetes, chronic back pain, history of femur fracture, ljustment disorder with writis. The most recent MDS was a quarterly assessment ment Reference Date) of was coded as being in ability to make daily life int was coded as requiring ning; limited assistance for in for hygiene, toileting, is. Is notes revealed one dated ented, "A change in the afternoonOrders D (no new orders)" This | F 6 | 3. Nurse Practice Educator, and or designee to in-service 100% of licensed nursing on process for reviewing revising a care plan. 4. ADON, Nurse Practice Educated and or designee will audit care plans weekly for 4 withen randomly thereafter ensure care plans are reviand revised as appropriate Variances will be corrected immediately and brought Quality Assurance and Performance Improveme Committee monthly, with QAPI Committee responsion for ongoing compliance. 5. Date of Compliance: 3/15 | vice staff and ucator i 20 eeks, r, to iewed ee. ed i to | |



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER (X2) A. BL | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--|---|--|---------------------|---|-------------------------------|--|--|--|
| | | 495246 | B. WING_ | | C 02/07/2019 | | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLET | | | |
| F 657 | what, if any, new intercare plan. Subsequer following days failed information regarding. A review of the "Ever 11/8/18 documented room trying to reach stuffed cats. Resident state hurt after a few minsing get up from the floor was assessed for an foundIntervention and care plan update on not leaning while. A review of the compreveal any evidence reviewed and/or reviewed and/or reviewed and/or reviewed and/or reviewed to Primary did not document the fall, if there were any, new intervention plan. Subsequent in following days failed information regardin. A review of the "Ever 12/24/18 document." | if there were any injuries, and erventions were added to the ent nurses' notes over the to reveal any additional g the details of the fall. Int Summary Report" dated if, "Resident feel sic in dining across the table to get her ent fell to floor and hit her ed that her head no long sic in the interest | F | 557 | | | | |
| | and care plan update on not leaning while A review of the compressed any evidence reviewed and/or reported to Primary did not document the fall, if there were any, new intervention plan. Subsequent information regarding A review of the "Evental Parameter and the floor beside her ROM (range of motions). | ed: Resident was educated in chair." prehensive care plan failed to that the care plan was ised following this fall. e's notes revealed one dated umented, "A change in noted. The symptoms /18 in the morningChange Care Clinician" This note e circumstances surrounding any injuries, and what, if one were added to the care curses' notes over the lato reveal any additional in the gent Summary Report" dated | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | E CONSTRUCTION | a Prince of State | SURVEY PLETED | | |
|--|---|--|---------------------|--|------------------------------|----------------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | 495246 | B. WING | STREET ADDRESS, CITY, STATE, ZIP CO | | 07/2019 | |
| | ONT CENTER | | | 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 657 | initiatedInterventifall and care plan up alarm prior to fall, all A review of the commerceal any evidence reviewed and/or reviewed and reviewed | ons added immediately after odated: Resident had disabled farm was replaced." prehensive care plan failed to e that the care plan was rised following this fall. se's notes revealed one dated mented, "A change in condition he symptoms include: orted to Primary Care obtained included: Continue to be complaints of buttocks pain "This note did not document surrounding the fall and if ries, and what, if any, new added to the care plan." 'notes over the following days additional information | F 657 | | | | |
| | A review of the "Eve 1/1/19 documented the CNA (Certified I instructed to pull ca The resident did no floor near her bed immediately after fa Staff to remain with bathroom." A review of the commevee all any evidence reviewed and/or reviewed and/or reviewed of the nurs 1/6/19, which documents. | ent Summary Report" dated , "The resident was toileted by Nursing Assistant) was Il bell when she was done. It was noted to be lying on theInterventions added Ill and care plan updated: Ithe resident while in the Inprehensive care plan failed to the that the care plan was rised following this fall. Se's notes revealed one dated mented, "A change in condition the symptoms include: Falls | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | (X2) MULTIPLE CO A. BUILDING | | C | (X3) DATE SURVEY COMPLETED C | |
|--|--|--|--|---|--|----------------------------|
| | ROVIDER OR SUPPLIER | 453240 | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE |
| F 657 | 1/6/19 documented, changes in the ROM body ache" A thir documented, "NP of the falls this am the There was no incide provided. These notes did not surrounding the fall interventions were a Subsequent nurses' failed to reveal any regarding the details. A review of the compreveal any evidence reviewed and/or reveal any evidence reviewed and/or reveal any evidence reviewed and/or reveal any evidence reviewed. The morningChan ClinicianOrders of observation" This circumstances surround injuries, and who were added to the contest over the followed additional information fall. A review of the "Evez/3/19 documented toileted and wanted toileted and wanted toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted to the contest of the "Evez/3/19 documented toileted and wanted to the contest of the theory of the "Evez/3/19 documented toileted and wanted to the contest of the contes | g." A second note dated "The resident has no new I, usual complaints of general d note dated 1/6/19 (nurse practitioner)aware here are no new orders." Intreport related to this fall document the circumstances and what, if any, new added to the care plan. notes over the following days additional information | F 657 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|--------------------------|---|---|-----------------------------|---|------------------------------|--|--|
| | | 495246 | B. WING | DOMESTIC STREET | 02/07/2019 | | |
| 318 | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE COMPLETION | | |
| F 657 | she was found in a bed. The residents she was assisted vinerself up and place Neuro checks were added immediately updated: Continue encouragement to a review of the compression of the | s off and her feet slipped and kneeling position next to her shoes were placed on and a a gait belt which she pushed led into her w/c (wheelchair). InitiatedInterventions after fall and care plan deducation and the compliant." In prehensive care plan failed to be that the care plan was wised following this fall. In p.m., an interview was A #1 (Certified Nursing sked what a care plan is, CNA the size information about how to with the was the was care plan, CNA #1 stated, when asked if she has the let." In p.m., in an interview with LPN in it is an interview with LPN in it is an interview with the let. In the work what the plan, LPN #2 stated, when asked what was letter plan, LPN #2 stated, legrity, UTI (urinary tract lested, "nursing and | F 65 | 7 | | | |
| | all you need so you particular resident." information is on a "diagnoses, skin in infection)." When a care plan, LPN #2 administration." Wand revise the care | know what to do for a ' When asked what care plan, LPN #2 stated, tegrity, UTI (urinary tract asked who has access to the stated, "nursing and hen asked who can review plan, LPN #2 stated, "the unit rector of nursing - Nurse | | | | | |
| | | 7 a.m., in an interview with RN se), when asked about the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (× | 3) DATE SURVEY COMPLETED | |
|---|---|--|---|---------|---|----|----------------------------|--|
| | | 495246 | B. WING _ | B. WING | | | 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | | |
| (X4) ID PREFIX TAG | | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 657 | "Communicate will resident, its update needs change." We found on a care period and skin care." On 2/7/19 at approximate Executive Director Member] #1) and were made aware that the "Event Stephone to the comment and is record. At this time legal clinical recorded. | plan, RN #5 stated, th all staff about the needs of a ed constantly as the residents then asked what information is lan, RN #5 stated, "Care needs, aily living), diagnoses, oxygen, oximately 2:20 p.m., the r (ASM [Administrative Staff the Executive Nurse (ASM #2) of the concern. ASM #2 stated ammary Report" is an internal not part of the legal clinical ne, she was notified that the rd did not reflect the above data e fall occurred, if there were any are were any care plan reviews | F6 | 557 | | | | |
| | Care Plan" docume individualized care days after complete assessment for emeasurable object patient's medical, and psychosocial comprehensive a be:7.2 Reviewe interdisciplinary to including both the review assessment response to care goals" | cility policy, "Person-Centered nented, "A comprehensive, e plan will be developed within 7 etion of the comprehensive ach patient that includes ctives and timetables to meet a nursing, nutrition, and mental needs that are identified in the ssessments7. Care plans will d and revised by the earn after each assessment, e comprehensive and quarterly ints, and as needed to reflect the and changing needs and | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | (X2) MULTIPI A. BUILDING B. WING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 02/07/2019 |
|---|---|--|--|---|--|
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| F 657 | Continued From pag | e 110 | F 65 | 7 | |
| | Resident #31's compreviewed and/or revi | orehensive care plan was sed after a fall on 1/18/19. | | M | |
| | 5/26/18 with the diaghigh blood pressure, atrial fibrillation, pactontracture, seizures acute kidney failure. (Minimum Data Set) with an ARD (Assess 11/5/18. The resider cognitively intact in a | dmitted to the facility on gnoses of but not limited to cardiomyopathy, stroke, emaker, dementia, s, chronic kidney disease and The most recent MDS was a quarterly assessment sment Reference Date) of nt was coded as being ability to make daily life tent was coded as requiring | | | |
| | total care for bathing dressing, toileting ar assistance for eating | ; extensive care for transfers, nd hygiene; and limited J. | | | |
| | 1/18/19, which docu condition has been r include: Falls 1/18/1 to Primary Care Clin document the circun if there were any inju | e's notes revealed one dated mented, "A change in noted. The symptoms 19 at nightChange reported ician" This note did not nstances surrounding the fall, uries, and what, if any, new | | | |
| | Subsequent nurses | dded to the care plan. notes over the following days additional information to the fall. | 3 | = | |
| 7. | 1/18/19 documented down beside his bed ROM [range of motion "I am trying to grab | ont Summary Report" dated if, "Resident was found face if with no injuries, tolerated ion] well, res [resident] stated isomething from the floor" | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII | PLE CONSTRUCTION G | | E SURVEY APLETED C | | | |
|--------------------------|--|---|---|---|--|--------------------|---------------------------------|----------------------------|--|
| | | 495246 | B WING_ | 1 2 Then - T | 0 | 2/07/2019 | | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | DEFICIENCY MUST BE PRECEDED BY FULL PREFIX | | ECTION IOULD BE PROPRIATE | (X5) COMPLETION DATE | |
| F 657 | - | l and care plan updated: | F 6 | 57 | | | | | |
| | A review of the compreveal any evidence reviewed and/or reviewed aware of that the "Event Sum document and is not record. At this time, legal clinical record regarding how this face | orehensive care plan failed to that the care plan was seed following this fall. imately 2:20 p.m., the ASM [Administrative Staff e Executive Nurse (ASM #2) if the concern. ASM #2 stated mary Report" is an internal a part of the legal clinical she was notified that the did not reflect the above data all occurred, if there were any e any care plan reviews or | | | | | | | |
| | the survey. 3. The facility staff of Resident #15's compreviewed and/or reversed and/or rever | te kidney injury, pacemaker, rt failure. The most recent a Set) was a quarterly ARD (Assessment 10/18/18. The resident was | | | | | | | |
| | make daily life decis | nitively impaired in ability to sions. The resident was extensive care for bathing; | | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | (X2) MULTIP A. BUILDING B. WING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 02/07/2019 | | |
|--|---|--|---|---|-------------|----------------------------|
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | 0772013 |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | N SHOULD BE | (X5) COMPLETION DATE |
| F 657 | independent for d | rage 112 insfers and toileting; and was ressing, eating, and hygiene. incal record revealed a nurse's | F 65 | 7 | | |
| | change in condition symptoms included nightChange reconstruction ClinicianOrders (physical therapy) status." This note circumstances sure any injuries, and were added to the notes over the following symptoms. | 9, which documented, "A on has been noted. The c: Fall on 1/28/19 at ported to Primary Care obtained include: Have PT eval (evaluate) for functional edid not document the rrounding the fall, if there were what, if any, new interventions a care plan. Subsequent nurses lowing days failed to reveal any tion regarding the details of the | | | | |
| | 1/28/19 documen help, entered res on the floor betwee holding on to bed checks, abrasion NP (nurse practiti PT [physical there (responsible party abrasion and res (activities of daily immediately after Refer to PT, enc before getting on A review of the coreveal any evider reviewed and/or On 2/7/19 at app | tvent Summary Report" dated ted, "heard res (resident) calling room and observed her sitting ten w/c [wheelchair] and bed., and w/c, on neuro [neurological] to upper mid-back, no bleeding. oner) made aware and ordered apy] to eval [evaluate], res rp v) made aware of fall with need for more assist with ADLs living)Interventions added fall and care plan updated: (encourage) res to call for assist to (out of bed)." Imprehensive care plan failed to be that the care plan was revised following this fall. | | | | м С |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | A. BUILDIN | PLE CONSTRUCTION G | CON | (X3) DATE SURVEY COMPLETED C 02/07/2019 | |
|--|--|---|---------------------|--|--|----------------------------|
| | ROVIDER OR SUPPLIER | 400240 | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | 210112019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENT | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 657 | were made aware of that the "Event Sum document and is not record. At this time, legal clinical record regarding how the farm any injuries, and if the reviews or revisions. No further information the survey. 4. The facility staff of Resident #35's community community and returning on leave of all unsupervised, and returning within the ordered. Resident #35 was a 5/22/18 with the dial hip fracture, atrial fill falls, inguinal hernial most recent MDS (Aquarterly assessme Reference Date) of coded as being cog daily life decisions, being independent of dressing, eating, to supervision for hyginal and the clinifollowing: | the concern. ASM #2 stated mary Report" is an internal apart of the legal clinical she was notified that the did not reflect the above data all occurred and if there were mere were any care plan on was provided by the end of ailed to evidence that prehensive care plan was the resident's behaviors of osences from the facility his non-compliance with specified 4-hour window as dmitted to the facility on gnoses of but not limited to orillation, high blood pressure, and cardiomyopathy. The Minimum Data Set) was a not with an ARD (Assessment 11/23/18. The resident was notively intact in ability to make The resident was coded as for transfers, locomotion, leting and required | F 6 | 57 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | | A, BUILDING B, WING | LE CONSTRUCTION | (X3) | (X3) DATE SURVEY COMPLETED C | |
|--|--|--|---------------------|---|--|------------------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | 495246 | B, WING | STREET ADDRESS, CITY, STATE, ZIP CODE | ************************************** | 02/07/2019 | |
| WOODMO | ONT CENTER | | | 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | 4.23 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 657 | might go on LOA (le on 8/3/18 to go to th A physician's order resident might go or A review of the nurs following: A nurse's note dated "Resident has order resident left the faci at 3pm. Safety main monitor." A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. A nurse's note dated change in condition symptoms include: agitation, psychosis No further information. | ave of absence) for 4 hours he bank. dated 8/13/18 that the h LOA for 4 hours on 8/13/18. dated 8/15/18 that the h LOA for 4 hours on 8/15/18. dated 8/21/18 that the h LOA for 2 hours on 8/21/18. dated 8/22/18 that the h LOA for 4 hours daily. he's notes revealed the d 8/15/18 that documented, for LOA for 4 hrs [hours], lity at 99:45 {sic} but not back hained will continue to d 8/15/18 that documented, "A has been noted. The Behavioral symptoms (e.g. b) 8/15/18 in this afternoon" on was documented. d 8/16/18 documented, "Late his dent was observe by this ff news paper (sic.) on the hig A-Jax / urine on the news huring A Jax in urinal full of his k why and resident stated I his dish detergent works the hie practitioner) to make aware hal status N.O. (new order) 2} in the AM resident own RP | F 65 | 7 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|--|--------------------------------------|-------------------------------|--|
| | | 495246 | B. WING | | | C 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 657 | that he was going going to church to contacted at 10 proposed to back at facility contacted. Residus soon after and was call. Unit manage Firestone off of (let a nurse's note daentry: This RN was residents (Sic.) fa following his department. Nursing contact with RP to resident was local contact was made and friend, neither whereabouts. Do Nursing staff was office non emerger residents (Sic.) fa 10:30 pm, this RN (resident) had call was at the Fireston due to not having This writer went to Resident was four (location) sitting of he left his bank cowas unable to get to facility. This R resident of return need to be able to Resident express was asked where leaves the facility | out at 1:30pm, today and stated at to (name of bank) and not onight. Cousin and friend were in today because resident was y. Unit manager on call was ent made contact with facility as reported to unit manager on er will pick up resident from | F 6 | 57 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDIN | IG | COMPLETED | |
|--------------------------|---|---|---------------------|--|--------------------|--|
| | | 495246 | B, WING | | C 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE COMPLETION | |
| F 657 | usually in the shor | of bank) on (location) and is ping center above or below the t returned to facility at | F 6 | 857 | | |
| | A nurse's note dat "Patient left facility supposed to return facility at 7:50p.m. Station in (location returned at 9:30p. the Bus Station ga education given or out alone he must | ed 10/3/18 documented, at 2:10p.m., for LOA was by 6:10p.m Patient called to say he was at the Bus by with no way back. Patient m. He stated, "Someone from the me a ride back." Patient by Safety and if Patient is going have money for Cab fare both return back on time." | | | | |
| | "Met with patient, Member - the Oml Nurse Executive) visits. He has had out in the commun home after 10pm. be in building whe meds. Resident of this time. SW (so him a Medicaid ph (resident) is willing he has a cell phor of (the facility). An church on Sunday transportation bot we will reopen the community. Discrept to (facility) to go to the bank. Taccess to his mor a snack. He was | note dated 10/5/18 documented, (OSM #14 - Other Staff budsman) CNE (former Center to discuss resident's community if two instances where he was nity and unable to get a ride. Discussed safety and need to in he is scheduled to get his loes not have a cell phone at cial worker) is working to get lone. After discussion get to agree to the following. Until he he will not leave the property in exception will be to attend as they will provide he ways. Once he has a phone ediscussion of his trips into the lassed changing his check to therefore eliminating his need to his would also allow him to have level daily if he wants to purchase agreeable to do this. | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | COMPLETED | | | |
|--------------------------|--|---|---------------------|--|---------------------|--|--|
| | XI III | 495246 | B. WING | | C 02/07/2019 | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE COMPLETION | | |
| F 657 | contact social work needed." A review of the care evidence that the reunsupervised, or his returning timely way on 2/7/19 at 1:24 p (licensed practical resident's activity of unsupervised, and timely should be cashould have been. On 2/7/19 at 2:20 p conducted with the [Administrative State Executive Nurse (Athe resident's unsufficiently and issert facility timely, ASM and oriented, his B Status exam) was stated the physicial outings and that it wanted to. When a planning of his unsufficiently in the planning of his uns | his own words. He will and the ombudsman as e plan failed to reveal any esident's community visits is non-compliance with s care planned. o.m., in an interview with LPN nurse) #4, when asked if the of leaving the facility noncompliance with returning are planned, LPN #4stated it o.m., an interview was executive Director (ASM off Member] #1) and the aSM #2). When asked about prevised outings into the ues he had of returning to the l #1 stated that he was alert esiMS (Brief Interview for Mental a 15 (cognitively intact). She in was aware of the resident's was his right to go out if he asked about the lack of care supervised outings and the returning timely, ASM #1 we been care planned. | F 65 | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|-------------------------------|
| | | 495246 | B. WING | and the same of the same | C 02/07/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | VISUA PARTY |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION |
| F 657 | Continued From pa | ge 118 | F 65 | , | |
| | weight loss, fever of weakness, bruising cancer · When you are rec | e check-up symptoms, such as fatigue, or other signs of an infection, i, bleeding, or any signs of seiving treatments (medicines ay change your blood count | | | |
| | results To monitor a long- | -term (chronic) health problem our blood count results, such | T-D | any sector in a m | |
| | Information obtaine https://medlineplus | ed from .gov/ency/article/003642.htm | | 118 36 E. AIII | |
| | frequently ordered healthcare practitio about the current s metabolism, includinglucose level, and balance. Abnormal combinations of ab problem that needs Information obtained https://labtestsonlinel-bmp 5. The facility staff | ing health of the kidneys, blood electrolyte and acid/base results, and especially normal results, can indicate a s to be addressed." | | | |
| 1 | 4/23/18. Resident were not limited to and high blood pre recent MDS (minim assessment with a date) of 2/1/19, cocognitively intact. | dmitted to the facility on #1's diagnoses included but low back pain, bladder cancer ssure. Resident #1's most num data set), an admission n ARD (assessment reference ded the resident as being Section G coded Resident #1 | | · · · · · · · · · · · · · · · · · · · | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING _ B. WING | CONSTRUCTION | co | TE SURVEY MPLETED C 02/07/2019 |
|--------------------------|---|---|-------------------------------------|--|--------------------------------|---------------------------------|
| | NT CENTER | | 1 | TREET ADDRESS, CITY, STATE, ZIP CO I DAIRY LANE REDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 657 | Section O coded the therapy during the Review of Resident physician's order of oxygen, at two liter Resident #1's care reveal documentate administration. On 2/5/19 at 9:24 at #1 was observed soxygen via a nasa On 2/6/19 at 4:05 conducted with LP LPN #3 was asked LPN #3 stated, "So how to really care require any equipmasked if an oxygen plan should be revoxygen administra When asked why, is being treated with he has should be of On 2/6/19 at 5:39 member) #1 (the enurse executive) as specialist) were miconcern. | fers and personal hygiene. The resident as receiving oxygen last 14 days. It #1's clinical record revealed a lated 1/25/19 for continuous is per minute via nasal cannula. I plan dated 1/29/19 failed to ion regarding oxygen The a.m. and 10:58 a.m., Resident sitting up in bed receiving a cannula. The purpose of a care plan. The purpose of a care plan. The nursing staff can know for the resident and if they ment or anything really. When a dependent resident's care riewed and revised to include tion, LPN #3 stated, "Yes." LPN #3 stated, "That's what he th here and he has it; so what | F 657 | | | |

| STATEMENT OF CO | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING B. WING | CONSTRUCTION , | | DATE SURVEY COMPLETED C 02/07/2019 |
|---|--|--|---|---|--------------------------------------|---|
| NAME OF PRO | VIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | 020112019 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE |
| 66 FP FOO nh FF on the FF | Resident # 309's comprehensive discontinue Foley (Inc.) The "Physician Tellor (Inc.) The "Physician Tel | failed to review and/or revise are plan to reflect the ordiscontinue a Foley catheter. Is admitted to the facility on agnoses that included but were na (2), respiratory failure (3), and anxiety (5). Indicate recent MDS (minimum assion assessment with an ARD ence date) of 01/30/19, coded scoring a 15 on the brief all status (BIMS) of a score of 0 gnitively intact for making daily and # 309 was coded assistance of one staff member by living. Under section "H" Resident # 309 was coded as a section and the was lying in her bed by nasal cannula. Further to evidence a catheter. When catheter Resident # 309 stated are plan for Resident # 309 with a revision date of cented, "Focus. Resident are catheter due to: neurogenic anterventions" it documented, need of catheter. Date | F 657 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|--|--------------------|
| | | 495246 | B. WING | | C 02/07/2019 |
| | ROVIDER OR SUPPLIER | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405 | 02307/2010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE COMPLETION |
| F 657 | conducted with RN coordinator and LPN 6, MDS nurse. Afte Telephone Order" d. 309 and the compre 02/04/2019 for a Fo # 6 stated, "When the nursing should have plan. When there is status or there are revise/update the carrievise/update the carr | is p.m., an interview was (registered nurse) # 6, MDS N (licensed practical nurse) # r reviewing the "Physician ated 02/01/19 for Resident # shensive care plan dated dey catheter, RN # 6 and LPN ne catheter was discontinued a revised or updated the care a change in the resident's new, orders nursing should are plan. It wasn't done." roximately 5:50 p.m., ASM member) #1, the executive 12, executive nurse, were above findings. on was provided prior to exit. er is a tube placed in the body urine from the bladder. This rained from the website: gov/ency/article/003981.htm. and by fluid in your body's mation was obtained from the a.gov/medlineplus/edema.html. gh oxygen passes from your ad. This information was | F 657 | | |
| | | sure. This information was | | | is. |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495246 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED C 02/07/2019 | | |
|---|---|--|--|---|---|----------------------------|--|
| | PROVIDER OR SUPPLIER | 2002-00-20 | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | 02/07/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE BE APPROPRIATE | (X5) COMPLETION DATE | |
| F 657 | essure.html. (5) Fear. This inform website: https://www.nlm.nih. #summary. Services Provided M | ebsite: gov/medlineplus/highbloodpr nation was obtained from the gov/medlineplus/anxiety.html | F 65 | | | | |
| | The services provide as outlined by the comust- (i) Meet professional This REQUIREMEN' by: Based on clinical recand review of facility staff failed to ensure the administration of (Resident #35) in the residents. The facility staff failed was notified, consulted obtained to administe Resident #35, when the facility late, over an hor administering two The facility staff initial p.m., schedule medical | rehensive Care Plans and or arranged by the facility, imprehensive care plan, standards of quality. This not met as evidenced cord review, staff interview documentation the facility professional standards for medications for one resident survey sample of 55 If to evidence the physician and that orders were are two medications late to the resident returned to the our past the scheduled time prescribed medications. led/documented two 8:00 ations as administered and documented the resident | | 1. Resident #35, AE the physician on medications bein late. 2. All residents are Physician not bein medication being late. 100% audit residents Medica Administration R last 30 days were Center Nurse Exe and or Designee, any missed or late administration withe physician 3. Nurse Practice Ed ADON or designed 100% of licensed on proper physician when medications administered late | 2/6/19 of the ag administered at risk for administered of current ation ecords for the audited by acutive, ADON to ensure that a medication as notified to acutive or, et o in-service nursing staff an notification is are | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | (X2) MULTIF A. BUILDING B. WING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 02/07/2019 |
|--------------------------|---|---|---------------------------------------|--|---|
| | PROVIDER OR SUPPLIER | | - 12 | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | 1 020112010 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| F 658 | 5/22/18 with the diag hip fracture, atrial fib falls, inguinal hernia most recent MDS (M quarterly assessmer Reference Date) of coded as being cogr daily life decisions, being independent for dressing, eating, toils supervision for hygie A review of the clinic physician's order dat the resident may go for 4 hours daily. | dmitted to the facility on gnoses of but not limited to prilation, high blood pressure, and cardiomyopathy. The linimum Data Set) was a not with an ARD (Assessment 11/23/18. The resident was notively intact in ability to make the resident was coded as or transfers, locomotion, eating and as requiring one. | F 65 | 4. Audit of 10 random MARS, to be complete by ADON of designee 5 X week for 4 was and randomly thereafter, to review for medications delivered late to ensure the Physician was notified appropriately. Variances we corrected immediately and brought to Quality Assurar and Performance Improves Committee monthly, with a Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/19 | or eeks, to at vill be d nce ment QAPI |
| | following: A nurse's note dated "Resident signed out that he was going to going to church tonig contacted at 10pm to not back at facility. Ucontacted. Resident soon after and was recall. Unit manager w Firestone off of (local A nurse's note dated entry: This RN was cresidents (Sic.) failure following his departur afternoon. Nursing scontact with RP to se | 8/30/18 documented, at 1:30pm, today and stated (name of bank) and not ht. Cousin and friend were day because resident was Unit manager on call was made contact with facility eported to unit manager on ill pick up resident from ion)" 8/31/18 documented, "Late contacted by nursing staff of et or return to the facility re for the bank earlier in the taff was advised to make | | 1 compliance. 3/15/19 | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING B. WING | PLE CONSTRUCTION | COM | E SURVEY MPLETED C 2/07/2019 | |
|--------------------------|--|--|--|---|-----------|-------------------------------|--|
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 658 | and friend, neither of whereabouts. DON Nursing staff was at office non emergence residents (Sic.) failud 10:30pm, this RN work (resident) had called was at the Firestone due to not having endure to get at the facility. This RN resident of returning need to be able to the Resident expressed was asked where heleaves the facility sknow where to look goes to the (name of the substance o | with residents (Sic.) cousin of which knew of his was notified of incident. divised to call the sheriffs (Sic.) by number to report the re to return. At approximately as notified by staff that dithe facility and stated he and was unable to get back hough money for the cab ride. Dick up resident shortly after. In front of the Firestone the ground. Resident stated di (Sic.) back at the facility and ride back. Resident returned stressed the importance to the gin a timely manner and the ake his evening medicine. If understanding, Resident e usually goes when he of another incident occurs we. Resident stated that he of bank) on (location) and is bring center above or below the returned to facility at | F 65 | 58 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|---|---|--|--|------------------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | 433240 | | REET ADDRESS, CITY, STATE, ZIP CODE | 02/07/2019 | |
| | NT CENTER | | 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETION | |
| F 658 | Continued From pag | e 125 | F 658 | | | |
| | dated 5/23/18 for Ca daily for calcium sup | I-Gest {1}, 1 tab (tablet) twice plement; and a Metoprolol s) twice daily for high blood | | | | |
| | Administration Reco resident was to rece 8:00 p.m. On 8/30/1 documented as adm | st 2018 MAR (Medication rd) documented that the live the above medications at 8, these medications were inistered at 8:00 p.m., when | | ≅ | | |
| | not present in the bu and 11:30 p.m. The physician was notifie | cumented in nurses' notes, as idding between 1:30 p.m., re was no evidence that the ed, consulted and orders were er the medications late. | | | | |
| | that the resident was medications above a these medications w administered at 8:00 documented in nurse building between 2:1 was no evidence tha | p.m., when the resident was es' notes as not being in the 0 p.m. and 9:30 p.m. There it the physician was notified, s were obtained to administer | | | | |
| | #4, was asked about when a resident is o miss medications. LI | m., in an interview with LPN t the process staff follows ut on leave long enough to PN #4 stated the physician rerify if the medications can | | | | |
| | Executive Director (/ member] #1) and Nu When asked about t | m., in an interview with the ASM [administrative staff arse Executive, ASM #2. he resident's unsupervised munity and issues he had of | | | | |

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED C | |
|---|--|--|---------------------|---|----------|------------------------------|--|
| | | 495246 | B. WING | 814 | 1 0 | 2/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | 20112013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 658 | he was alert and orie Interview for Mental 3 (cognitively intact). Saware of the resident right to go out if he wabout the resident's rwas late returning to that the doctor should direction provided whem (medications) is standard of practice of the facility policies and A review of the facility Absence/Therapeutic direction on procedur past a medication time. A review of the facility Resident Discharge of Change of Status" do physician/prescriber resident to take a lead physician/prescriber medications the resident change in the time for medication, if approposend that dose of medication did not ad should be if the resident. | y timely, ASM #1 stated that nted, his BIMS (Brief Status exam) was a 15 she stated the physician was 's outings and that it was his anted to. When asked missed medications when he the facility, ASM #1 stated d have been notified and nether or not to administer ate. When asked what the facility follows, she stated and procedures. If policy, "Leave of the Leave" did not include the and missed medications. If policy, "Leave of Absence, with Medication or Other ocumented, "When a Facility provides an order for the ve of absence, the should specify the lent is to take with them are resident is taking a leave of a 24 hours, consider a radministration of a riate, to avoid the need to dication with the resident" dress what the procedure ent's leave was to be brief, ed the medications due to a | F 6 | 58 | 11; | | |
| | Administration: Gene | ed, "Medication ral" documented, "A licensed medication aide, per state | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 127 of 206



| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING | | LTIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED C | |
|--|--|--|---------------------|---|-----------|------------------------------|--|
| | | 495246 | B. WING | | | 2/07/2019 | |
| | NT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | The Vision | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 658 | Continued From pag | ge 127 | F 65 | 3 | | | |
| | patientslf discrepa physician/advanced and/or pharmacy as | practice provider (APP) indicated" | | | | | |
| | dietary supplement calcium taken in the is needed by the bo muscles, nervous sy carbonate also is us heartburn, acid indig is available with or valinformation obtained | I - "Calcium carbonate is a used when the amount of diet is not enough. Calcium dy for healthy bones, ystem, and heart. Calcium led as an antacid to relieve gestion, and upset stomach. It without a prescription." | | | | | |
| F 684 SS=E | combination with off blood pressure. It all (chest pain) and to attack. Metoprolol a with other medicatic Metoprolol is in a cliblockers. It works be slowing heart rate to decrease blood prefinformation obtained https://medlineplus. | | F 68 | 4 | | | |
| | § 483.25 Quality of Quality of care is a | care fundamental principle that ent and care provided to | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION N | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED C 02/07/2019 |
|---|--|---|--|---|---|
| | WOODMONT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLETION |
| F 684 | facility residents. Be assessment of a resident residents rece accordance with puractice, the comp care plan, and the This REQUIREME by: Based on resident facility document review, it was deterailed to follow physprofessional standaresidents in the sur The facility staff fail medication Advair to order on multiple displanuary 2019. The findings include The facility staff fail medication Advair (physician's order or 2018 and January 2018 and January 2019. Resident #71 was a 10/1/18. Resident were not limited to disease (2), low back Resident #71's mosset), a quarterly asset (assessment refere resident as being controlled the service of Resident Review of Review of Resident Review of Resident Review of Resident Review of Review o | assed on the comprehensive esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced interview, staff interview, eview and clinical record remined that the facility staff sician's orders and ards of practice for one of 55 evey sample, Residents #71. The detection of the facility of the facility of the facility on the facility of the facility on the facility on the facility on the facility of the facility on the facility of the facility of the facility of the facility on the facility of the facility | F 68 | F684: 1. Resident #71 staff f administer Advair in 2018 and January 2 2. All residents have p be affected. 100% Medication Administered for current the last 30 days was to ensure that med were administered physician's order, a deviations noted we corrected by complementation for designee to 100% of licensed number on administration of medication, to included ocumentation of nedivery. | n November 2019. Dotential to audit of stration cresident for scompleted ications according to ny ere etion of eport and on. cator, ADON in-service ursing staff of ide |

PRINTED: 02/22/201 FORM APPROVE OMB NO. 0938-039

| _ | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|--------------------|---|---|----------------------------|
| | | 495246 | B. WING | | ľ | C / 07/2019 |
| | ROVIDER OR SUPPLIER | 2 | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | <u> </u> | 10712019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | OULD BE | (X5) COMPLETION DATE |
| F 684 | every 12 hours. Revie November 2018 and Comedication administrative reveal Advair was administrative and the following of the following and the following an | mcg and to inhale one puffew of Resident #71's lanuary 2019 MARs ation records) failed to ininistered to the resident k spaces with no initials) on 11/1/18 at 9:00 p.m., and 1/23/19 at 9:00 p.m., and 1/23/19 at 9:00 p.m. e dates failed to reveal the inistered. Further review of ry 2019 MAR revealed istered to the resident on d 9:00 p.m., 1/18/19 at 9:00 a.m. and on 20 these dates, the nurses d documented the railable on the back of the resident exhibits or is at an interview was ent #71. The resident ing his Advair as he was the but that had " ", an interview was censed practical nurse) #3. We nurse evidence the ments they administer. Sign off on the MAR tion record) and TAR." | F | 4. ADON and or designed audit 10 random Medical Administration Record week for 4 weeks their randomly thereafter to medications are administrations are administration are administrations. Date of Compliance: 3 | iation ds 5 X n o ensure nistered | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 130 of 206



| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | E SURVEY PLETED C | |
|--|---|--|---|---|-------------------------|---|--|
| 10.20 | boy to the same of | 495246 | B. WNG | M | 02/0 | | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C | | (EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | |
| F 684 | not sign off, LPN at that they didn't do meant if nurses si MAR. LPN #3 stacircled, either they are supposed to e LPN #3 was aske facility STAT (Imm various medication resident if needed contained in the faprovided by that p various medication each resident). Lifacility process for administration, if r #3 stated, "They of the right dose, the not, let the physicipatient know, call (the medication) if pharmacy) and let that you didn't giv made aware of the Resident #71's Admurses would run "really quick" becathe medication on opposed to a typic doses. LPN #3 siget the Advair out would not release too soon for a refisomeone maintain building). LPN #3 call the pharmacy bill the facility and asked if Resident | age 130 #3 stated, "In reality it means it." LPN #3 was asked what is gn and circle their initials on the sted, "Usually if signed and wheld it, or couldn't give it, they explain on the back of the MAR." dif Advair is contained in the sediate) box (a box containing ins that can be accessed for any and it.). LPN #3 stated Advair is acility omnicell (a machine sharmacy, containing many ins that can be accessed for PN #3 was asked about the rensuring Advair is available for not in the medication cart. LPN can check the omnicell. If it's expensively will let you pull it. If it is an know it's not here, let the the pharmacy and ask to send from backup (a backup it the rp (responsible party) know it." At this time, LPN #3 was is surveyor's concern regarding shair. LPN #3 stated in the past, out of Resident #71's Advair ause the disk device containing ly contained 14 doses as call device that contains 60 and device that contains 60 and nurses used to attempt to of the omnicell but the omnicell the medication because it was lil (except for one time when hing the omnicell was in the a stated nurses would have to and authorize the pharmacy to a send the medication. When #71 missed doses of his Advair, we have the would tell us he got it | F 684 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--|--|---------|-------------------------------|--|
| | | 495246 | B. WING | | 0 | C 2/07/2019 | |
| | ROVIDER OR SUPPLIER | | 11 DA | ET ADDRESS, CITY, STATE, ZIP CODE MRY LANE DERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 684 | (the disk) and it w investigated." LPI disk displays how device. LPN #3 coasked if nurses she pharmacy refill for medication ran out have addressed to doses left. On 2/6/19 at 5:39 member) #1 (the concern) member of the nurse executive) aspecialist) were moncern. The facility policy Administration: Gonurse, Med Tech, regulations, will apatients If discreto the available, not in provider (APP) are not available, not in the second of the second o | as empty; then I further N #3 was asked if the Advair many doses are left in the confirmed it did. LPN #3 was rould have addressed a r the medication before the at and stated nurses should the refill when there were four p.m., ASM (administrative staff executive director), ASM #2 (the and ASM #3 (the clinical quality hade aware of the above titled, "Medication eneral" documented, "A licensed or medication aide, per state dminister medications to epancies, including medication fy physician/advanced practice ad/or pharmacy as indicated" ation was obtained prior to exit. It to treat difficulty breathing, ess of breath, coughing, and aused by asthma. This obtained from the website: as.gov/druginfo/meds/a699063.h are to substances that irritate and are main cause of COPD is are to substances that irritate and as. This is usually cigarette | F 684 | | | | |

PRINTED: 02/22/201 FORM APPROVE OMB NO. 0938-039

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|--------------|---|---|----------------------------|
| | | 495246 | B. WING | | | 1 | C /07/2019 |
| | ROVIDER OR SUPPLIER | | | 11 DAIRY LAN | ESS, CITY, STATE, ZIP CODE IE SBURG, VA 22405 | 1 02 | 10712019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION CACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 684 | can also cause it." The from the website: https://vsearch.nlm.nimeta?v%3Aproject=nmedlineplus-bundle&c76.178186840.155010688 Treatment/Svcs to Procerois (Season) Skin Integ §483.25(b)(1) Pressure Based on the compressional standard pressure ulcers and dulcers unless the individemonstrates that the (ii) A resident with prenecessary treatment a with professional standpromote healing, prevnew ulcers from devel This REQUIREMENT by: Based on staff intervice and clinical record reveled the treatment of a presidents in the survey | chemical fumes, or dust his information was obtained higov/vivisimo/cgi-bin/query- hedlineplus&v%3Asources= query=copd&_ga=2.959716 60688-1667741437.155016 event/Heal Pressure Ulcer ii)(ii) rity re ulcers. hensive assessment of a ust ensure that- care, consistent with s of practice, to prevent oes not develop pressure ridual's clinical condition y were unavoidable; and ssure ulcers receives and services, consistent dards of practice, to ent infection and prevent | | 2. | Resident #29 staff failed provide pressure injury treatment as prescribed. Residents' requiring presinjury treatment are at ri 100% audit of treatment administration records focurrent residents with wowas completed to ensure ordered treatments were administered according to order. Nurse Practice Educator, and or designee to in-servation providing pressure injure treatment as prescribed in the servation of the | sure sk. or ounds that o ADON vice staff ury | |
| | | ent as prescribed by the dates in October 2018 and | je | i | physician. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 133 of 206



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE (| (X3) DATE S COMPLE | | |
|---|--|--|---------------------|---|---|---------------------------|
| = 1 = 1 | Na Table | 495246 | B. WING | | <u>'</u> | 7/2019 |
| | PROVIDER OR SUPPLIER | | 11 | REET ADDRESS, CITY, STATE, ZIP C DAIRY LANE EDERICKSBURG, VA 22405 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE 'HE APPROPRIATE | (X5) COMPLETIO DATE |
| F 686 | 8/11/18. Resident # were not limited to u and abnormal posturecent MDS (minimul Medicare assessme reference date) of 1' cognition as modera coded Resident #29 assistance of one struse and personal hy Resident #29 as havinjury (1) that was provided Resident #3 three-pressure injury 10/29/18 documente (left) buttock (with) Norep to wound edges cover (with) dry dres (as needed) (illegible #29's October 2018, (treatment administrate evidence that the tre was provided for Residence that | | F 686 | 4. ADON and or des 10 Treatment Ad Records 5 X week weeks then rande thereafter to ens are provided per Variances will be immediately and Quality Assurance Performance Imp Committee mont Committee respongoing complian 5. Date of complian | ministration k for four omly ure treatments order. corrected brought to e and provement chly, with QAPI onsible for | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | | СОМІ | (X3) DATE SURVEY COMPLETED C 02/07/2019 | |
|--------------------------|---|--|---|---|----------|--|--|
| | NT CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | A SA | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 686 | Further review of R report for October 2 revealed the reside deteriorate during to 11/8/18 documente breakdown related pressure wound to treatment as ordered On 2/6/19 at 4:05 p conducted with LPL LPN #3 was asked medications and to LPN #3 stated, "The (medication adminioration when asked what spaces on the MAR not sign off, LPN # that they didn't do in 12/6/19 at 5:39 p | 2018 and November 2018 2018 and Action Action 2018 and Action | F 684 | | | | |
| | nurse executive) a specialist) were ma concern. The facility policy t Management" doctor Special Wound Ca indicated and order to further information (1) "Pressure Injury in the special was a special work or further information." | and ASM #3 (the clinical quality ade aware of the above sitled, "Skin Integrity umented, "4.7 Implement re treatments/techniques, as red." | | | 10 14 | | |

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-039*

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|----------------------------|
| | | | 130 | | | С | |
| | | 495246 | B. WING | | | 02/ | 07/2019 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | · | |
| WOODMO | NT CENTER | | | | 1 DAIRY LANE | | |
| | | | | F | REDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 686 | Continued From page | e 135 | F | 686 | | | |
| | device. The injury car open ulcer and may be as a result of intense or pressure in combir tolerance of soft tissue may also be affected perfusion, co-morbiditissue. Stage 3 Pressure Injury Full-thickness loss of is visible in the ulcer epibole (rolled wound Slough and/or eschar of tissue damage var areas of significant as wounds. Undermining Fascia, muscle, tende and/or bone are not expended to be a constant of the constant o | n present as intact skin or an pe painful. The injury occurs and/or prolonged pressure nation with shear. The performance and shear by microclimate, nutrition, ties and condition of the soft and granulation tissue and ledges) are often present. If may be visible. The depth performance is by anatomical location; diposity can develop deep grand tunneling may occur. In ligament, cartilage exposed. If slough or eschar of tissue loss this is an elinjury." This information | | | | | |
| F 689 | prescription medicine from wounds so they information was obta https://www.santyl.co | e that removes dead tissue can start to heal." This ined from the website: | F | 689 | | | |
| SS=E | S483.25(d) Accidents The facility must ensing s483.25(d) The re as free of accident has | (2) s. ure that - sident environment remains azards as is possible; and | | | | | |
| | §483.25(d)(2)Each re | esident receives adequate | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 136 of 20



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|---|---|-------------------------------|--|
| | | 495246 | B. WING | | 02 | C /07/2019 | |
| | PROVIDER OR SUPPLIER | | 11 | REET ADDRESS, CITY, STATE, ZIP COD DAIRY LANE REDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE EAPPROPRIATE | (X5) COMPLETION DATE | |
| F 689 | supervision and as accidents. This REQUIREMEI by: Based on observa record review, and was determined the ensure that four of sample (Resident # provided a safe ensupervision to previnjuries, or harm. 1. The facility staff was assessed to deable to go out into the safely, and allowed unsupervised, unmalone, without a friehim at risk of poten Resident #35 was dexcessively late ret and did not have a contact him to check documented as coroccasions in which money to return to the facility staff failed to identified at the time falls for Resident #35 suffacility staff failed to facility staff | NT is not met as evidenced tion, staff interview, clinical facility document review, it at the facility staff failed to 55 residents in the survey #35, 31, #15 and #39) were viorment and adequate ent potential accidents, failed to ensure Resident #35 etermine if the resident was the community unsupervised I the resident to have conitored leaves of absences, end of family with him, putting tial accidents, injuries. documented as being urning to the facility at times cell phone so the facility could ex on his safety, and was intacting the facility on 2 he did not have a ride or the facility late at night. Instained a fall on 1/18/19. The primplement interventions are of the fall to prevent further stained a fall on 1/28/19. The primplement interventions are of each fall to prevent further | F 689 | 1. Resident #35 a place created to allow habsences with a fin Resident #31, 15 a had fall intervention implemented and of care. 2. Residents' requiring absence without or residents who fall 100% audit of cur who have had fall days was completed that interventions implemented and plan accordingly. Services/Activities reviewed current sign themselves of ensure that approximate their safet outings. | nim leave of riend present, and 39 have ions ladded to plan ing leave of chaperone and lare at risk. It is in the last 30 ted to ensure is were ladded to care Social is Director residents that out LOA to opriate in place to | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--------|---|---|--|
| | | 495246 | B. WNG | | C 02/07/2019 | |
| , , , , , , , | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE ACTION SHOULD I | | |
| F 689 | 12/24/18, 1/1/19, 1/staff failed to implei the time of each fall Resident #39. The findings include 1. Resident #35 was 5/22/18 with the diahip fracture, atrial fifalls, inguinal herniamost recent MDS (If quarterly assessme Reference Date) of coded as being cog daily life decisions. being independent dressing, eating, to supervision for hygical A review of the clinifollowing: A physician's order may go on LOA (leas 8/3/18 to go to the last A physician's order resident may go on A review of the nurs following: | 6/19, and 2/3/19. The facility ment interventions identified at to prevent further falls for es: as admitted to the facility on gnoses of but not limited to brillation, high blood pressure, a, and cardiomyopathy. The Minimum Data Set) was a nt with an ARD (Assessment 11/23/18. The resident was nitively intact in ability to make The resident was coded as for transfers, locomotion, leting; and required ene. cal record revealed the dated 8/2/18 that the resident we of absence) for 4 hours on | F 689 | 3. Nurse Practice Eduand or designee to 100% of licensed on leave of absent evaluation for supports unsupervisional implementing into post falls. 4. ADON and or designee to 5X a week x 4 weekly thereafter that care plans are with new interver falls to prevent furbally and I Quality Assurance Performance Implementing into post falls. 5. Date of compliance. 5. Date of compliance. | nursing staff nces including pervision sed visit and erventions ignee to audit absence eave. ADON o audit all falls eks and r to ensure e updated ntions post erther falls. corrected brought to e and rovement ng monthly ttee ngoing | |

| Contact Contact Contact | CONTRACTOR SECURIOR S | ND HUMAN SERVICES MEDICAID SERVICES | | | The state of the s | NTED: 02/22/2019 FORM APPROVEI B NO. 0938-0391 |
|--------------------------|--|---|---------------------|---|--|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | | DATE SURVEY COMPLETED | |
| | | 495246 | B. WING | Same and the same of the same | | C 02/07/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | team of the state | STR | EET ADDRESS, CITY, STATE, ZIP CO | DE | 02/07/2019 |
| WOODMO | NT CENTER | | | DAIRY LANE EDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENT | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | Continued From pag | ge 138 | F 689 | | | |
| | left the facility at 99: | for LOA for 4 hrs, resident 45 {sic} but not back at 3pm. ill continue to monitor." | | | | |
| | "A change in condition | i 8/15/18, that documented, on has been noted. The Behavioral symptoms (e.g. | | | | |
| 19 | | 8/15/18 in this afternoon" | ! | | | |
| | Entry for 8-15-18 res writer and other staf floor resident pourin | l 8/16/18, documented, "Late sident was observe by this f news paper (Sic.) on the g A-Jax / urine on the news | | | | |
| | urine. This writer as wanted to see what best. Call NP (nurse of the altered menta | ring A Jax in urinal full of the why and resident stated I dish detergent works the expressioner) to make aware I status N.O. (new order) in the AM resident own RP | | | | |
| | "Resident signed ou that he was going to going to church toni contacted at 10pm t not back at facility. contacted. Residen | t 8/30/18 documented, t at 1:30pm, today and stated (name of bank) and not ght. Cousin and friend were oday because resident was Unit manager on call was t made contact with facility | | | | |
| | | reported to unit manager on will pick up resident from ation)" | | | | |
| | entry: This RN [regi by nursing staff of re to the facility following earlier in the afterno | d 8/31/18 documented, "Late istered nurse] was contacted esidents (Sic.) failure to returning his departure for the bank ion. Nursing staff was intact with RP to see if they | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|--|--------------------------------|----------------------------|
| | | 495246 | B. WING_ | | | C 02/07/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | knew where resident advised that contact (Sic.) cousin and frie his whereabouts. DO Nursing staff was advoffice non emergency residents (Sic.) failur 10:30pm, this RN wa (resident) had called was at the Firestone due to not having end This writer went to pix Resident was found (location) sitting on the left his bank card was unable to get a to facility. This RN s resident of returning need to be able to tax Resident expressed was asked where he leaves the facility so know where to look, goes to the (name of usually in the shoppi hospital. Resident reapproximately 11:30 A nurse's note dated "Patient left facility as supposed to return be facility at 7:50p.m., to Station in (location) returned at 9:30p.m. the Bus Station gave education given on Station in gi | was located. This RN was was made with residents and, neither of which knew of DN was notified of incident. Vised to call the sheriffs (Sic.) by number to report the eto return. At approximately is notified by staff that the facility and stated he and was unable to get back ough money for the cab ride. It is compared to the facility and stated (Sic.) back at the facility and ride back. Resident stated (Sic.) back at the facility and ride back. Resident returned the stated that he is evening medicine. Understanding. Resident usually goes when he if another incident occurs we Resident stated that he facility at pm." 10/3/18 documented, the compared to facility at pm." 10/3/18 documented, the stated, "Someone from the stated, "Someone from the stated, "Someone from the end a ride back." Patient Safety and if Patient is going are money for Cab fare both | F | 689 | | |

PRINTED: 02/22/201! DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 689 Continued From page 140 F 689 A social services note dated 10/5/18 documented, "Met with patient, (OSM #14 - Other Staff Member - the Ombudsman) CNE (former Center Nurse Executive) to discuss resident's community visits. He has had two instances where he was out in the community and unable to get a ride home after 10pm. Discussed safety and need to be in building when he is scheduled to get his meds (medication). Resident does not have a cell phone at this time. SW (social worker) is working to get him a Medicaid phone. After discussion (resident) is willing to agree to the following. Until he has a cell phone he will not leave the property of (the facility). An exception will be to attend church on Sunday as they will provide transportation both ways. Once he has a phone we will reopen the discussion of his trips into the community. Discussed changing his check to come to (facility) therefore eliminating his need to go to the bank. This would also allow him to have access to his money daily if he wants to purchase a snack. He was agreeable to do this. (Resident) was able to state what the outcome of the meeting was in his own words. He will contact social work and the ombudsman as needed." A review of the care plan failed to reveal any

evidence that the resident's community visits unsupervised, or his non-compliance with returning timely was care planned.

On 2/6/19 at approximately 2:00 p.m., in an interview with RN #1 (Registered Nurse) she stated that she was not aware of the "Ajax" incident. She stated that the resident used to go out of the facility but has not in a long time unless a friend is with him. She did not recall anything else about the resident's incidents about being

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CO | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | |
|--------------------------|--|--|---|--|---|----------------------------|--|--|
| | | 495246 | B. WING | | Charles No. | 02/07/2019 | | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | 'STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION EACTION SHOULD BE O TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE | | |
| F 689 | On 2/7/19 at 1:05 #3 (Licensed Pract the resident going stated, "He would take him out. He was done to ensur leave the facility u don't know what, it ensure he was sat asked process is f and said he could "The Facility finds asked about the in 8/31/18 nurse's no not get in contact the cab to get him the cab. The cab station) to find him go looking for him asked what the far #35's safety outsid don't know. He no friend." LPN #3 s about the "AJax" i On 2/7/19 at 1:24 #4, when asked h to determine that, unsupervised, LPI or if he was asses | p.m., in an interview with LPN tical Nurse) when asked about out unsupervised, LPN #3 just call a cab or a friend would would either have cab money to wouldn't and would call the know where he was at so he When asked what assessment re the resident was safe to insupervised, LPN #3 stated, "I f any assessment was done to fe to go unsupervised." When followed if Resident #35 called not get back, LPN #3 stated, him a way to get back" When incident as documented in the ote, LPN #3 stated, "We could with the bus station. We called . I'm not sure why he didn't get would not go in (the bus in and the bus station would not to notify him of a cab." When cility did to ensure Resident de the facility, LPN #3 stated, "I to longer goes out without a lated she did not know anything | F 689 | | | | | |
| | of the resident lea get back to the fac | ving and then being unable to cility, LPN #4 stated, "I know sed about him having issues | | | | | | |

PRINTED: 02/22/201! DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ C B. WING 495246 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 689 Continued From page 142 F 689 getting back but I don't know what happened." When asked if the resident's activity of leaving the facility unsupervised, and noncompliance with returning timely should be care planned, LPN #4 stated it should have been. When asked about the process followed when the resident is out long enough to miss medications, LPN #4 stated that the physician should be called and verify if the medications can be given or not. When asked about the "AJax" incident, LPN #4 stated she did not know anything about it. On 2/7/19 at 2:20 p.m., an interview was conducted with the Executive Director (ASM [administrative staff member] #1) and Nurse Executive, ASM #2. When asked about the resident's unsupervised outings into the community and the issues he had of returning to the facility timely, ASM #1 stated that he was alert and oriented, his BIMS (Brief Interview for Mental Status exam) was a 15 (cognitively intact). She stated the physician was aware of the resident's outings and that it was his right to go out if he wanted to. When asked what assessment was done to ensure that the resident was safe to go out unsupervised, ASM #1 stated that if the IDT (Interdisciplinary team) felt he was safe to do so that is what they chose to do. ASM #1 was not employed at the facility at the time of the incidents when the resident came back late to the facility and was unable to provide any documented evidence of an assessment of the resident or discussions of his unsupervised activities by the IDT team.

When asked about the A-Jax incident ASM #1 stated the facility does not use A-Jax and

presumed he brought the cleaner in with him from one of his outings, but she was unable to find any

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
|--|--|--|--|-----|--|------------------------------|----------------------------|
| | | 495246 | B. WNG | | | | 07/2019 |
| | ROVIDER OR SUPPLIER | | | 11 | REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE REDERICKSBURG, VA 22405 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 689 | incident. When asker planning of his unsup noncompliance with restated it should have asked about the reside when he was late retistated that the doctor and provided direction them late. ASM #1 with documented in the clinary and an episode of psone outing (the AJax bringing question to his afe when unsupervisanything was done at #35 being out excess transportation or common at least two occas it is his (Resident #35 wanted because he with made his own decision maybe he (Resident because he might have his own equipment at was unable to locate incident (administration employed at the facility speak on it. When asked about the was used to determine unsupervised, ASM it is she stated that it maybe conversation and was formal assessment to that the facility apparamentally able to leave | entation or soft file of the d about the lack of care | F | 689 | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 144 of 20



| NAME OF STREET, WILLIAM STATES | | ND HUMAN SERVICES MEDICAID SERVICES | | And Advantages | FO | ED: 02/22/2019 RMAPPROVED NO: 0938-0391 |
|--------------------------------|--|--|---------------------|---|-----------------------------------|---|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO | INSTRUCTION | | TE SURVEY MPLETED |
| | | 495246 | B. WING | | | 2/07/2019 |
| NAME OF PR | ROVIDER OR SUPPLIER | | STRE | ET ADDRESS, CITY, STATE, ZIP (| | 20172010 |
| WOODMO | NT CENTER | | 100 | AIRY LANE DERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | safe to do so. ASM employed at the faci (Resident #35) has s | d that the facility felt he was #1 stated that she was not lity at that time, but that he since had a physical decline ger went out of the facility | F 689 | | | |
| | On 2/7/19 at 2:49 p.: conducted with RN # speak with the surve at the facility but was the resident's leave and no longer worke survey). RN #12 sta 8/31/18, that when the was at the bus st return, an Uber was return to center, arri- waited 10 minutes a notified the ombuds that the resident did | m., a phone interview was #12, (who the facility called to by team, because she worked is not on duty at the time of when he was late returning and at the facility at the time of the ted that regarding the night of the resident called and stated atton and was unable to called for the resident to wed at the bus station and and left. She stated the facility man next day. RN #12 stated not have cell phone with him and able to let him know that | | | | |
| | #14, the Ombudsma worked with the resi came to this facility. facility and talked at was calling her sayin him leave. OSM #1 to make decisions to She stated that he li community, even where he has friend come back. OSM # be back and could residue. | m., in an interview with OSM an, she stated that she has dent since before he ever. She stated she met with the bout his history because he ng the facility would not let 4 stated he had a high BIMS ogo out into the community. kes to go out into the nen at prior facilities, to go here is a community area, she liked to go to and would 14 stated he knew he had to not stay out over night. OSM in he initially came to the | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|--|----------------------------|----------------------------|--|
| | | 495246 | B. WING | 41 3 15 16 16 1 | | C 02/07/2019 | |
| | NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405 | ĐĒ | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X5) COMPLETION DATE | |
| F 689 | measures were pua friend, so it woul need money for cabeing away from the return). She state resident to have fure couple of times lost excuse that." OSI working with him resubsidized housin friend says there is been looking at it that this just happethat since has he been helping with put things in place he was safe to do. The social worker the above incident as of a few days be could not be intended as of a few days be could not be intended as of the facility of the faci | ncern for the facility. However, at in place for him to go out with a dobe safe and he would not abs (this was after 2 incidents of the facility without a means to do it was addressed with the ands for cab or transportation. The facility does have the eep him safe, and that "I know to the safe, and that "I know to the safe, and that the safe was bad and there is no way to with the safe. She stated that his is now for discharge to a go setting. She stated that his is a house available and have to ensure a safe discharge and the end today (2/7/19). She stated been at the facility, she had placement. She stated, "We to ensure if he wanted to leave so." who was at the facility during the was no longer at the facility before the survey and therefore viewed. attion could be provided, and apployed at the time either, no a facility, or did not recall there was not observed going the days of sident was not observed going. | F 68 | 9 | | | |

PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ C 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) Continued From page 146 F 689 F 689 · As part of a routine check-up · If you are having symptoms, such as fatigue, weight loss, fever or other signs of an infection, weakness, bruising, bleeding, or any signs of · When you are receiving treatments (medicines or radiation) that may change your blood count results · To monitor a long-term (chronic) health problem that may change your blood count results, such as chronic kidney disease." Information obtained from https://medlineplus.gov/ency/article/003642.htm {2} BMP - "The basic metabolic panel (BMP) is a frequently ordered panel of 8 tests that gives a healthcare practitioner important information about the current status of a person's metabolism, including health of the kidneys, blood glucose level, and electrolyte and acid/base balance. Abnormal results, and especially combinations of abnormal results, can indicate a problem that needs to be addressed." Information obtained from https://labtestsonline.org/tests/basic-metabolic-pa nel-bmp 2. Resident #31 sustained a fall on 1/18/19. The facility staff failed to implement interventions identified at the time of the fall to prevent further falls for Resident #31. Resident #31 was admitted to the facility on

5/26/18 with the diagnoses of but not limited to high blood pressure, cardiomyopathy, stroke, atrial fibrillation, pacemaker, dementia,

contracture, seizures, chronic kidney disease and acute kidney failure. The most recent MDS

PRINTED: 02/22/201! DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039⁻ (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING C 495246 B. WING 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 689 Continued From page 147 F 689 (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/5/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; and limited assistance for eating. On 2/5/19 at 10:07 a.m., and on 2/6/19 at 1:14 p.m., a observations were made of Resident #31. There were no concerns identified. A review of the nurse's notes revealed one dated 1/18/19, which documented, "A change in condition has been noted. The symptoms include: Falls 1/18/19 at night....Change reported to Primary Care Clinician...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/18/19 documented, "Resident was found face down beside his bed with no injuries, tolerated ROM well, res stated "I am trying to grab something from the floor" denies any pain/discomfort....Interventions added immediately after fall and care plan updated:

Educated resident to use call bell at all times."

prevent further falls. The intervention documented in the "Event Summary Report"

A review of the comprehensive care plan failed to reveal any evidence Resident # 31's care plan was reviewed and/or updated following this fall to

PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495246 B. WNG 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 689 Continued From page 148 F 689 above was not included/documented and implemented on the care plan. The resident's care plan documented as follows: "Resident is at risk for falls: CVA (stroke), Impaired mobility, cognitive loss, lack of safety awareness, syncopal episode." This care plan was dated 10/13/15, and most recently revised on 12/10/18. The interventions were as follows: "12/17/18 - Offer/assist resident with urinal/commode as requested/needed." (Created on 12/10/18). "Place bedside table within reach on left side." (Created on 12/9/15 and revised on 3/9/18). "Medication evaluation as needed." (Created on 9/20/17). "8/10/18 Provide resident/caregiver education for safe techniques." (Created on 8/13/18). "Place call light within reach at all times." (Created on 10/13/15). "Remind resident to use call light when attempting to ambulate or transfer." (Created on 10/13/15). "When resident is in bed, place all necessary personal items within reach." (Created on 10/13/15). "Monitor for and assist toileting needs." (Created on 10/13/15). There was no evidence that after the fall on 1/18/19, that the effectiveness of the above interventions were reviewed and modifications made if necessary to include interventions implemented to prevent further falls for Resident

On 2/06/19 at 1:47 p.m., an interview was conducted with CNA #1 (Certified Nursing Assistant). When asked what a care plan is, CNA

#31.

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|--|--|--|-------------------------|---|------------------------------|---|
| | | 495246 | B. WING_ | | 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | 02072010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETION | N |
| F 689 | | ge 149 asic information about how to | F6 | 689 | | |
| | | When asked if she has ents care plan, CNA #1 stated, et." | | N | | |
| | #2 (Licensed Practice the purpose of a care all you need so you particular resident." information is on a ce "diagnoses, skin inte infection)." When a care plan, LPN #2 s administration." When a care plan, LPN #3 and revise the care manager, DON (dire Executive at this face On 2/07/19 at 11:27 #5 (Registered Nurs purpose of a care p "Communicate with resident, its updated needs change." Wh | care plan, LPN #2 stated, egrity, UTI (urinary tract sked who has access to the stated, "nursing and nen asked who can review plan, LPN #2 stated, "the unit ector of nursing - Nurse cility)" Ya.m., in an interview with RN se), when asked about the lan, RN #5 stated, all staff about the needs of a d constantly as the residents sen asked what information is | | | | |
| | adl (activities of dail and skin care." | n, RN #5 stated, "Care needs, ly living), diagnoses, oxygen, | | | | |
| | Executive Director of Member] #1) and the were made aware of that the "Event Sundocument and is not record. At this time legal clinical record regarding how the femal support that the support of the su | kimately 2:20 p.m., the (ASM [Administrative Staff the Executive Nurse (ASM #2) of the concern. ASM #2 stated the mary Report" is an internal to part of the legal clinical to, ASM #2 was notified that the did not reflect the above data fall occurred, if there were any to were any care plan reviews | | | | |

| Screen Stray VI | Attitists (Seven transmission of | AND HUMAN SERVICES & MEDICAID SERVICES | | | FOR | D: 02/22/2019 MAPPROVED O: 0938-039 | |
|---|---|--|---------------------|--|---------|---|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT(PLE C | ONSTRUCTION | | (X3) DATE SURVEY COMPLETED C 02/07/2019 | |
| | | 495246 | B. WING | | 0: | | |
| NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER | | | 11 (| REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 689 | A review of the factor Plan" documendividualized care days after complete assessment for earneasurable object patient's medical, and psychosocial comprehensive as be:7.2 Reviewer including both the review assessment response to care a goals" | ny interventions implemented to | F 689 | | | | |
| | facility staff failed | sustained a fall on 1/28/19. The to implement interventions ne of each fall to prevent further \$15. | | | | H | |
| | 7/9/15 with the dia atrial fibrillation, hi hypothyroidism, a and congestive he MDS (Minimum D assessment with a | admitted to the facility on agnoses of but not limited to igh blood pressure, cute kidney injury, pacemaker, eart failure. The most recent ata Set) was a quarterly an ARD (Assessment of 10/18/18. The resident was | | | | | |

coded as mildly cognitively impaired in ability to make daily life decisions. The resident was

PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495246 B. WING 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 689 Continued From page 151 F 689 coded as requiring extensive care for bathing; supervision for transfers and toileting; and was independent for dressing, eating, and hygiene. On 2/5/19 at 9:15 a.m., and at 11:26 a.m., observations were made of Resident #15. There were no concerns identified. A review of the clinical record revealed a nurse's note dated 1/28/19, which documented, "A change in condition has been noted. The symptoms include: Fall on 1/28/19 at night....Change reported to Primary Care Clinician....Orders obtained include: Have PT (physical therapy) eval (evaluate) for functional status." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/28/19 documented, "heard res (resident) calling help, entered res room and observed her sitting on the floor between w/c [wheelchair] and bed., holding on to bed and w/c, on neuro [neurological] checks, abrasion to upper mid-back, no bleeding. NP (nurse practitioner) made aware and ordered PT to eval, res rp (responsible party) made aware of fall with abrasion and res need for more assist with ADLs (activities of daily living)....Interventions added immediately after fall and care plan updated: Refer to PT [physical therapy], enc (encourage) res to call for assist before getting oob (out of bed)."

A review of the comprehensive care plan failed to

PRINTED: 02/22/2019 FORM APPROVEL OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: | A. BUILDIN | IG | COMPLETED | | |
|---|--|--|---------------------|--|--------------------|--|--|
| | | 495246 | B. WING_ | | 02/07/2019 | | |
| ! | NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | # 6.55250 21.54 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE COMPLETION | | |
| F 689 | reveal any evidence was reviewed and/o prevent further falls. documented in the "above, were not inclimplemented on the The resident's care "Resident is at risk f Diagnosis of vertigo loss, lack of safety a requires assistance plan was dated 1/26 revised on 3/15/18. follows: "3/15/18 OT (occupi w/c (wheel chair) po "Assist resident in g assessment." (Created on 1/26/15, "Remind resident to attempting to ambut 1/26/15, revised on "Monitor for and asson 1/26/15, revised on 1/26/15, revised "1/2 side rails x 2 fo (Created on 2/4/15, There was no evide 1/28/19, that the eff interventions were made if necessary timplemented to pre #15. | Resident # 15's care plan r updated following this fall to The interventions Event Summary Report" luded/documented and care plan. plan documented as follows: for falls R/T (related to) Impaired mobility, cognitive awareness, history of falls and with transfers." This care 6/15, and most recently The interventions were as ational therapy) evaluation for esitioning." (Created 3/15/18). etting in and out of bed per lift ated 2/4/15, revised on in reach at all times." for revised on 7/11/15). In use call light when late or transfer." (Created on 7/11/15). Isist toileting needs." (Created on 7/11/15). Ir functional mobility." | F6 | 889 | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 153 of 20



PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE C | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|-------------------------------|--|
| | | | | | С | |
| | | 495246 | B. WING | | 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | 11 0 | REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION | |
| F 689 | Continued From page | ge 153 | F 689 | | | |
| | #1 stated, "All the bacare for a resident." | ked what a care plan is, CNA asic information about how to When asked if she has ents care plan, CNA #1 stated, et." | | | 3 | |
| | #2 (Licensed Practice the purpose of a care all you need so you particular resident." information is on a care diagnoses, skin interestion)." When a care plan, LPN #2 seadministration." When and revise the care | care plan, LPN #2 stated, egrity, UTI (urinary tract sked who has access to the tated, "nursing and hen asked who can review plan, LPN #2 stated, "the unit ector of nursing - Nurse | | | | |
| | #5 (Registered Nurs purpose of a care p "Communicate with resident, its updated needs change." Who found on a care pla | a.m., in an interview with RN se), when asked about the lan, RN #5 stated, all staff about the needs of a d constantly as the residents en asked what information is n, RN #5 stated, "Care needs, ly living), diagnoses, oxygen, | | | | |
| | Executive Director of Member] #1) and the were made aware of that the "Event Sundocument and is not record. At this time legal clinical record. | cimately 2:20 p.m., the (ASM [Administrative Staff for Executive Nurse (ASM #2) of the concern. ASM #2 stated formary Report" is an internal of part of the legal clinical for ASM #2 was notified that the did not reflect the above data fall occurred, if there were any | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 154 of 20



PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LISC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 689 Continued From page 154 F 689 injuries, and if there were any care plan reviews or revisions, including any interventions implemented to prevent further falls. No further information was provided by the end of the survey. 4. Resident #39 sustained falls on 11/8/18, 12/24/18, 1/1/19, 1/6/19, and 2/3/19. The facility staff failed to implement interventions identified at the time of each fall to prevent further falls for Resident #39. Resident #39 was most recently readmitted to the facility on 12/6/18 with the diagnoses of but not limited to dementia, diabetes, chronic back pain, high blood pressure, history of femur fracture, overactive bladder, adjustment disorder with anxiety, and osteoarthritis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/3/18. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for eating; and supervision for hygiene, toileting, dressing, and transfers. On 2/5/19 at 9:25 a.m., and on 2/6/19 at 2:11 p.m., observations were made of Resident #39. There were no concerns identified. A review of the nurse's notes revealed one dated

11/8/18, which documented, "A change in condition has been noted. The symptoms include: Falls 11/8/18 in the afternoon...Orders obtained include: NNO (no new orders)..." This

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED C | | | |
|--|--|--|------------------------------|--|--------------------|--|
| | ROVIDER OR SUPPLIER | 490240 | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | 02/07/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION | |
| F 689 | surrounding the fal what, if any, new ir care plan. Subseq following days faile information regarding to reach the subsequent of the "Eval" and the subsequent following days faile information trying to reach stuffed cats. Resident standard for a few minger up from the flow was assessed for a found Intervention and care plan update on not leaning while the fall and eview of the correveal any evidence was reviewed, update intervention, follow the fall, if there we any, new intervent the fall, if there we any, new intervent following days failed information regard. A review of the "Eval" and the subsequent following days failed information regard. | nent the circumstances I, if there were any injuries, and interventions were added to the uent nurses' notes over the id to reveal any additional ing the details of the fall. The ent Summary Report" dated ind, "Resident feel {sic} in dining in across the table to get her ident fell to floor and hit her ident fell to floor and hit her ident fell to floor and was able to increase the table to get her ident fell to floor and was able to increase the table to get her ident fell to floor and hit her ident fell to floor and hit her ident fell to floor and was able to increase the table to get her ident fell to floor and hit her ident fell to floor and hit her ident fell to floor and was able to increase the table to get her ident fell to floor and hit her ident | F 689 | | | |

PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) F 689 Continued From page 156 F 689 ROM (range of motion) well with no difficulty, vital signs were taken and neuro (neurological) checks initiated....Interventions added immediately after fall and care plan updated: Resident had disabled alarm prior to fall, alarm was replaced." A review of the comprehensive care plan failed to reveal any evidence that the care plan was reviewed updated to reflect the above intervention, following this fall on 12/24/18. A review of the nurse's notes revealed one dated 1/1/19, which documented, "A change in condition has been noted. The symptoms include: Falls....Change reported to Primary Care Clinician....Orders obtained included: Continue to monitor aware of the complaints of buttocks pain no bruising present" This note did not document the circumstances surrounding the fall and if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. A review of the "Event Summary Report" dated 1/1/19 documented, "The resident was toileted by the CNA (Certified Nursing Assistant) was instructed to pull call bell when she was done. The resident did not was noted to be lying on the floor near her bed....Interventions added immediately after fall and care plan updated: Staff to remain with the resident while in the bathroom." A review of the comprehensive care plan failed to reveal any evidence that the care plan was

reviewed, updated to reflect the above intervention, following this fall on 1/1/19.

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C | |
|---|--|---|--|--|--------------------------------|------------------------------|--|
| | | 495246 | B. WING | | | 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | DDE | 0210712019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 689 | 1/6/19, which documnas been noted. The 1/6/19 in the morning 1/6/19 documented, changes in the ROM body ache" A thirdocumented, "NP of the falls this am the There was no incide provided. These notes did not surrounding the fall a interventions were a Subsequent nurses' failed to reveal any a regarding the details. A review of the compreveal any evidence was reviewed and/or resident's falls on 11 1/6/19, and 2/3/19, to interventions documnary Report for included/documented care plan. The resident's care in Resident is at risk for safety awareness." 5/14/18 and most resident the interventions was reviewed and most resident the resident to | e's notes revealed one dated dented, "A change in condition e symptoms include: Falls g." A second note dated "The resident has no new do usual complaints of general do note dated 1/6/19 (nurse practitioner)aware here are no new orders." Interpretated to this fall document the circumstances and what, if any, new doded to the care plan. In notes over the following days additional information of the fall. Derehensive care plan failed to Resident # 39's care plan or updated following the 1/8/18, 12/24/18, 1/1/19, o prevent further falls. The ented on the "Event or each fall above, were not do and implemented on the plan documented as follows: or falls: cognitive loss, lack of This care plan was dated cently revised on 12/14/18. Here as follows: | F | 689 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | (X2) MULTIF A. BUILDING B. WING | PLE CONSTRUCTION G | СОМ | (X3) DATE SURVEY COMPLETED C | |
|--|--|---|---------------------|--|--------------------------------|----------------------------|
| | ROVIDER OR SUPPLIER | 743540 | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | V07/2019 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE |
| F 689 | safe techniques." (("Place call light with proximity to the bed. "12/13/18 - Remind when attempting to (Created on 12/14/1 place all necessary (Created on 5/14/18 "Implement the follo resident will wear no ambulating in room. There was no evide 12/24/18, 1/1/19, 1/6 effectiveness of the reviewed and modifinclude implemented further falls for Resident with the series of the reviewed and modifinal the series of the reviewed and modifinal the series of the seri | sident/caregiver education for Created on 6/22/18) in reach while in bed or close " (Created on 5/14/18) resident to use call light ambulate or transfer." 8) "When resident is in bed, personal items within reach." bwing safety precautions on-skid socks when " (Created on 10/22/18) ce that after falls on 11/8/18, 6/19, and 2/3/19, that the above interventions were cations made if necessary to di interventions to prevent | F 68 | 89 | | |
| | conducted with CNA Assistant). When as #1 stated, "All the bacare for a resident." access to the resident "Yes, it's on our table On 2/06/19 at 2:17 | A #1 (Certified Nursing sked what a care plan is, CNA asic information about how to When asked if she has ents care plan, CNA #1 stated, et." | | | | 2 |
| 25 | the purpose of a car all you need so you particular resident." information is on a c "diagnoses, skin int- infection)." When a care plan, LPN #2 s | care plan, LPN #2 stated, egrity, UTI (urinary tract sked who has access to the | | | | |

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

| MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|--|--|---|--|--|
| | 405046 | | | | ļ | 0 |
| POVIDED OD SLIDDLIED | 495246 | B. WING | STD | EET ADDRESS CITY STATE ZIP CODE | 02/ | 07/2019 |
| | | | 11 D | AIRY LANE | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | | | • | | (X5) COMPLETION DATE |
| and revise the care promanager, DON (direct Executive at this facility of the care plants | plan, LPN #2 stated, "the unit ctor of nursing - Nurse lity)" a.m., in an interview with RN e), when asked about the an, RN #5 stated, all staff about the needs of a constantly as the residents in asked what information is , RN #5 stated, "Care needs, living), diagnoses, oxygen, mately 2:20 p.m., the ASM [Administrative Staff executive Nurse (ASM #2) the concern. ASM #2 stated mary Report" is an internal part of the legal clinical ASM #2 was notified that the lid not reflect the above data ll occurred, if there were any were any care plan reviews g interventions implemented is. | F | 689 | | | |
| Respiratory/Tracheo CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care a The facility must ensineeds respiratory care care and tracheal su | ory care, including nd tracheal suctioning. sure that a resident who re, including tracheostomy ctioning, is provided such | F | 695 | | | |
| | ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page and revise the care page manager, DON (direct Executive at this facility of the continued of the care plant and communicate with a resident, its updated needs change." When found on a care plant and (activities of daily and skin care." On 2/7/19 at approxict Executive Director (Amember] #1) and the were made aware of that the "Event Summa document and is not record. At this time, legal clinical record or regarding how the fain injuries, and if there or revisions including to prevent further fall. No further information the survey. Respiratory/Tracheo CFR(s): 483.25(i) Respiratory care and tracheal survey care and tracheal survey. | A95246 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 159 and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, adl (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, ASM #2 was notified that the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any injuries, and if there were any care plan reviews or revisions including interventions implemented to prevent further falls. No further information was provided by the end of the survey. Respiratory/Tracheostomy Care and Suctioning | ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 159 and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, adl (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, ASM #2 was notified that the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any injuries, and if there were any care plan reviews or revisions including interventions implemented to prevent further falls. No further information was provided by the end of the survey. Respiratory/Tracheostomy Care and Suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such | ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 159 and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, ad (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record. At this time, ASM #2 was notified that the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any injuries, and if there were any care plan reviews or revisions including interventions implemented to prevent further falls. No further information was provided by the end of the survey. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such | ROWIDER OR SUPPLIER 10 STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LAME SUMMANY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MAST BE PRECEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) COntinued From page 159 and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Carmunicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Care needs, add (activities of daily living), diagnoses, oxygen, and skin care." On 2/7/19 at approximately 2:20 p.m., the Executive Director (ASM [Administrative Staff Member] #1) and the Executive Nurse (ASM #2) were made aware of the concern. ASM #2 stated that the "Event Summary Report" is an internal document and is not part of the legal clinical record did not reflect the above data regarding how the fall occurred, if there were any injuries, and if there were any care plan reviews or revisions including interventions implemented to prevent further falls. No further information was provided by the end of the survey. Respiratory/Tracheostomy Care and Suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such | A BUILDING 495246 ROWDER OR SUPPLIER NT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST OF DEFICIENCIES) (EACH DEFICIENCY) Continued From page 159 and revise the care plan, LPN #2 stated, "the unit manager, DON (director of nursing - Nurse Executive at this facility)" On 2/07/19 at 11:27 a.m., in an interview with RN #5 (Registered Nurse), when asked about the purpose of a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, its updated constantly as the residents needs change." When asked what information is found on a care plan, RN #5 stated, "Communicate with all staff about the needs of a resident, including the plan of th |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 160 of 20



| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
|--------------------------|--|---|---|---|--|
| NAME OF I | PROVIDER OR SUPPLIER | 495246 | B. WING | STREET ADDRESS, CITY, STATE, ZIP C | 02/07/2019 |
| WOODMONT CENTER | | | 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE | ON SHOULD BE COMPLETION HE APPROPRIATE DATE |
| F 695 | practice, the comp care plan, the resident 483.65 of this This REQUIREME by: Based on observation document review a was determined the provide respiratory to physician's order survey sample, Resident #1 at two physician's order. 1. The facility staff Resident #1 at two physician's order. 2. The staff failed to oxygen per physician. 3. The facility staff services according Resident #52. 4. The facility staff 309's oxygen according Resident #1 at two physician's order. Resident #1 was ac 4/23/18. | prehensive person-centered dents' goals and preferences, subpart. ENT is not met as evidenced ation, staff interview, facility and clinical record review, it at the facility staff failed to a care and services according or for four of 55 residents in the esidents #1, #51, #52 and #309. failed to administer oxygen to liters per minute, per to discontinue Resident #51's an's order. failed to provide respiratory to the physicians order for failed to administer Resident #rding to the physician's orders. | F 699 | F695 1. Resident #1 Oxy corrected while present, Resider was discontinue surveyor was present #309 or corrected while present. 2. All residents require are at risk. 100% completed by nucleadership of all residents with oxensure that flow the ordered rate current residents. Oxygen discontinue was accordingly. | surveyor was nt #51 oxygen d while esent, Resident corrected while esent and xygen was surveyor was uiring oxygen audit was ursing current xygen orders to rates are set at 100% audit of s who have had nued in the last riewed to r to |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION | Co | ATE SURVEY DMPLETED C |
|--------------------------|--|---|-----------------------------------|--|--|-----------------------------|
| | PROVIDER OR SUPPLIER | | 11 | FREET ADDRESS, CITY, STATE, ZIP COI DAIRY LANE REDERICKSBURG, VA 22405 | | 02/07/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 695 | intact. Section G con extensive assistance mobility, transfer and O coded the resident during the last 14 data. Review of Resident physician's order data oxygen, at two liters Resident #1's care preveal documentation administration. On 2/5/19 at 9:24 a. #1 was observed sitt oxygen via a nasal cobservation, the oxygen via a nasal cobservation, the oxygen via a nasal cobservation, the oxygen evidenced by the ballowmeter positioned and three-liter lines. On 2/6/19 at 4:05 p.r. conducted with LPN LPN #3 was asked to an oxygen concentrate resident has a physic LPN #3 stated the two through the middle of the order of the concern. On 2/6/19 at 5:39 p.m. member) #1 (the exenurse executive) and specialist) were made concern. | and ded Resident #1 as requiring to of one staff with bed dipersonal hygiene. Section at as receiving oxygen therapy that are the dipersonal record revealed a sted 1/25/19 for continuous per minute via nasal cannula. The permittent of the diperson oxygen that are the diperson oxygen oxygen that are the diperson oxygen | F 695 | Nurse Practice Educatesignee to in-service licensed nursing staff oxygen administration to include how to set concentrators on the setting. Education also no following orders to discontinue oxygen processes to | te 100% of fon correct on process, toxygen e correct lso includes to per orders. There to audit ceiving weeks, fter, to ery is done Variances mediately lity ormance nittee Committee cing | |
| = | confirmed the facility regarding oxygen adr | • • | | | | |

| THE CHARLES | NES SELLE CONTROL OF BUILDINGS | AND HUMAN SERVICES & MEDICAID SERVICES | | | | RM APPROVED NO, 0938-0391 |
|--------------------------|---|---|---------------------------------------|--|--|------------------------------|
| STATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) D/ | ATE SURVEY DMPLETED C |
| | | 495246 | B. WING | Language Tale | | 02/07/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | KWYSTELOWS WWW. | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| WOODMO | NT CENTER | | | 1 DAIRY LANE REDERICKSBURG, VA 224(|)5 | |
| (X4) ID PREFIX TAG | (EACH DEFICE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE, CROSS-REFERENCED DEFICI | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE |
| F 695 | Continued From p | page 162 | F 695 | | | |
| | documented, "No | entrator manufacturer's manual te: To properly read the | | | | |
| | the flowmeter. No ball rises to the lin | the prescribed flowrate line on ext, turn the flow knob until the ne. Now, center the ball on the nute) line prescribed." | | ž | | 100 |
| | | ation was obtained prior to exit. | | 22E | | |
| | 2. The staff failed oxygen per physic | to discontinue Resident #51's cian's order. | | 8 | | |
| | 6/28/18. Residen were not limited to and pneumonia. MDS (minimum dassessment with date) of 12/13/18, as severely impai #51 as requiring of more staff with be assistance of one | s admitted to the facility on at #51's diagnoses included but to diabetes, high blood pressure Resident #51's most recent that a set), a 14 day Medicare an ARD (assessment reference and coded the resident's cognition ared. Section G coded Resident extensive assistance of two or and mobility and extensive estaff with personal hygiene. | | | | |
| | a physician's orde on 1/15/19 that de | e last 14 days. ent #51's clinical record revealed er form signed by the physician ocumented an order for oxygen, ninute as needed. | | | | |
| | observed sitting unasal cannula. C #51 was observe via a nasal cannu the oxygen conce | a.m., Resident #51 was up in bed receiving oxygen via a on 2/5/19 at 4:43 p.m., Resident d lying in bed receiving oxygen ula. During each observation, entrator was set at a rate I a half and two liters as | | | | 3 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/22/2019

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | X2) MULTIPLE CONSTRUCTION A. BUILDING | | SURVEY PLETED |
|---|--|--|--------------------|---|--------------------------------|----------------------------|
| | | 495246 | B. WING | - 11 / W 8/4 | | C /07/2019 |
| | ROVIDER OR SUPPLIER ONT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 695 | flowmeter positione and two-liter lines. On 2/6/19 at 4:05 p conducted with LPI LPN #3 was asked an oxygen concent resident has a phys LPN #3 stated the through the middle On 2/6/19 at 5:39 p member) #1 (the expectable) at 5:39 p member) #1 (the expectable) are specialist) were maconcern. On 2/7/19 at 4:25 p presented a copy of resident #51 th order documented oxygen. ASM #2 acopy of Resident #51 th order documented oxygen. ASM #2 and was administered to when it should not because the physic discontinued. No further information. The facility staff resident #52, according to the composition of the composition o | all in the concentrator ad between the one and a half a.m., an interview was N (licensed practical nurse) #3. to describe where the ball in rator flowmeter should be if a sician's order for two liters. two-liter line should run | | 395 | | |

PRINTED: 02/22/201! DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039⁻ STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495246 B. WING 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 695 Continued From page 164 F 695 The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 12/15/18 coded the resident as having a score of 14 of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Section O-Special Treatment, documented that Resident #52 receives oxygen therapy. The physician order sheet dated January 2019 documented "Oxygen at 2 liters per minute via nasal cannula (A plastic tube with two prongs that inserts in the nose) continuously." Resident #52's comprehensive care plan dated 7/13/18 documented, "O2 (oxygen) as ordered." Review of the MAR (medication administration record) dated January 2019, for Resident #52 documented, "Oxygen at 2 liters per minute via nasal cannula continuously." The oxygen was signed off as administered to Resident #52 as evidenced by staff initials. On 2/5/19 at approximately 8:34 a.m., an observation was made of Resident #52. Resident #52 was observed receiving oxygen via a nasal cannula connect to an oxygen concentrator. Observation of the flowmeter on Resident #52's oxygen concentrator revealed the oxygen flow rate was set with the ball between the 2.0L/min (liters per minute) and 2.5L/min lines. On 2/5/19 at approximately 3:30 p.m., a second observation was made of Resident #52's oxygen

concentrator. Observation of the flowmeter on Resident #52's oxygen concentrator revealed the

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING B. WING | PLE CONSTRUCTION 3 | со | TE SURVEY MPLETED C 02/07/2019 |
|--------------------------|--|--|---------------------------------|---|--------------------------------------|---------------------------------|
| 10 | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 22405 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE |
| F 695 | the 2.0L/min (liters polines. On 2/5/19 at approxion observation was made oxygen concentrator (licensed practical nuterial read the flowmeter concentrator. After coxygen concentrator "its set at 2.5L (liters). On 2/5/19 at approximaterview was conductable was asked horead, LPN #1 replied supposed to be on the concentrator oxygen flowmeter is the dial until the line. The manufacturer's in #52's oxygen concentrator was conductable was conduc | mately 3:40 p.m., a third de with of Resident 52's flowmeter with LPN arse) #1. LPN #1 was asked on Resident #52's oxygen observing Resident #52's flowmeter, LPN #1 stated, b." mately 3:41 p.m., an otted with LPN #1. When we an oxygen flowmeter is per line." mately 3:45 p.m., an otted with RN (registered is asked how the rate on an otted with RN (registered is asked h | F 69 | 95 | | |

PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ C 495246 B. WNG 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 695 Continued From page 166 F 695 Executive, and ASM #3 were made aware of the findings. No further information was provided prior to exit. 1. A disease that makes it difficult to breath that can lead to shortness of breath. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution. chemical fumes, or dust can also cause it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. Your bone marrow is the spongy tissue inside some of your bones, such as your hip and thigh bones. It contains immature cells, called stem cells. The stem cells can develop into the red blood cells that carry oxygen through your body, the white blood cells that fight infections, and the platelets that help with blood clotting. If you have a myelodysplastic syndrome, the stem cells do not mature into healthy blood cells. Many of them die in the bone marrow. This means that you do not have enough healthy cells, which can lead to infection, anemia, or easy bleeding. This information was obtained from the website: https://medlineplus.gov/myelodysplasticsyndrome s.html 3. If you have anemia, your blood does not carry enough oxygen to the rest of your body. The most common cause of anemia is not having enough iron. Your body needs iron to make hemoglobin. Hemoglobin is an iron-rich protein that gives the

obtained from the website:

red color to blood. It carries oxygen from the lungs to the rest of the body. This information was

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | Υ |
|--------------------------|--|--|-------------------------|--|--|-----------------------|
| | | 495246 | 8. WING | | 02/07/201 | 10 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE COMPL E APPROPRIATE DA | X5) PLETION ATE |
| F 695 | meta?v%3Aproject medlineplus-bundl 2640.1704263304 2638661 4. The facility staff 309's oxygen according according to the facility staff 309's oxygen according to the facility staff 309's oxygen according to the facility staff 309's oxygen according to the facility staff according to th | in.nih.gov/vivisimo/cgi-bin/query-t=medlineplus&v%3Asources=e&query=anemia&_ga=2.7128 .1542638661-1154288035.154 If failed to administer Resident # ording to the physician's orders. Its admitted to the facility on agnoses that included but were ma (1), respiratory failure (2), and anxiety (4). In ost recent MDS (minimum assion assessment with an ARD ence date) of 01/30/19, coded scoring a 15 on the brief al status (BIMS) of a score of 0 agnitively intact for making daily int # 309 was coded as assistance of one staff member by living. Under section "O., Procedures and Programs" as coded for "C. Oxygen If a.m., an observation of aled she was lying in her bed by nasal cannula connected to trator that was running. If lowmeter on the oxygen aled an oxygen flow rate d-a-half liters and four liters per an's order sheet) for Resident # 2019"documented, "O2 to liters) via (by) N/C (nasal | F | 395 | | |

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | | TE SURVEY |
|--------------------------|--|--|--------------------|-------------------------------------|------------------------------|----------------------------|
| | | | 700,201 | | | С |
| 0 | | 495246 | B. WING | | | 02/07/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | | *** |
| | | | | 11 DAIRY LANE | | |
| WOODING | ONT CENTER | | | FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 695 | Continued From pa | ge 168 | F | 695 | | |
| | dated 01/25/2019 fa documentation for of On 02/05/19 at 4:48 Resident 309 was of | | | 1 | | |
| | to an oxygen conce Observation of the ficoncentrator reveal liters per minute. A # 4, LPN #4 stated the oxygen for Resi at four liters per min she adjusted the ox stated, "I don't reme often a resident's ox | en by nasal cannula connected entrator that was running. Flowmeter on the oxygen ed an oxygen flow rate of two this time in an interview LPN that she needed to readjust dent # 309 because it was up nute. When asked what time tygen flow rate, LPN # 4 ember." When asked how kygen flow rate is checked, | | | | |
| | and at the beginning describe how to real oxygen concentrate line should go throut On 02/06/19 at app (administrative staff | rery time I go into the room, g of the shift." When asked to ad the oxygen flow rate on the or LPN # 4 stated, "The liter agh the middle of the ball." roximately 5:50 p.m., ASM f member) #1, the executive #2, executive nurse, were above findings. | | | | а |
| | | on was provided prior to exit. | | | | |
| | tissues. This inforn website: https://www.nlm.nih | ed by fluid in your body's nation was obtained from the n.gov/medlineplus/edema.html. | | | | |
| l | ¡ (∠) vvnen not enoug | gh oxygen passes from your | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 169 of 20



| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
|--------------------------|--|---|---------------------------|---|--|
| | | 495246 | B. WING | | 02/07/2019 |
| | PROVIDER OR SUPPLIER ONT CENTER | | 11 1 | REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405 | 020112013 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE COMPLETIC |
| SS=E | lungs into your blocobtained from the whttps://www.nlm.nifilure.html. (3) High blood presobtained from the whttps://www.nlm.nifilessure.html. (4) Fear. This information website: https://www.nlm.nifilessure.html. (5) Fear. This information website: https://www.nlm.nifilessure.html. (6) Fear. This information website: https://www.nlm.nifilessure.html. (7) Fear. This information website: https://www.nlm.nifilessure.html. (8) Fear. This information website: https://www.nlm.nifilessure.html. (9) Fear. This information website: https://www.nlm.nifilessure.html. (1) Fear. This information website: https://www.nlm.nifilessure.html. (1) Fear. This information website: https://www.nlm.nifilessure.html. (2) Fear. This information website: https://www.nlm.nifilessure.html. (2) Fear. This information website: https://www.nlm.nifilessure.html. (3) High blood presobtained with the website website website website with the website websi | od. This information was vebsite: a.gov/medlineplus/respiratoryfa sure. This information was vebsite: a.gov/medlineplus/highbloodpr mation was obtained from the agov/medlineplus/anxiety.html Review-12 hr/yr In-Service) ar in-service education. applete a performance review at least once every 12 ar in-service the outcome of these raining must comply with the 8.95(g). T is not met as evidenced friew and facility document sined the facility staff failed to rmance reviews for 10 of 23 and assistants) who were one year. It to complete annual for CNA #1, CNA #2, CNA CNA #6, CNA #7, CNA #8. | F 730 F | 1. Annual performance were not completed for #1, 2, 3, 4, 5, 6, 7, 8, 9. 2. All CNA's in the facility risk for incomplete are performance reviews audit was complete by Resources to determine staff members that have performance review in the year, and performance is were completed according. | for CNA and 10. y are at nual 100% y Human current not had a the past reviews |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING B. WNG | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED C 02/07/2019 |
|--------------------------|---|--|---------------------|---|---|
| | ROVIDER OR SUPPLIER DNT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| | for the annual performs associated training's ASM (administrative executive. On 2/6/19 at 5:30 p. for the annual performs associated training's ASM #1, the execution clinical quality specifical quality | cimately 9:00a.m., a request rmance reviews and so for the CNAs was made to e staff member) #2, the nurse m., a second request made rmance reviews and so for the CNAs to ASM #2, ive director, and ASM #3, the alist. m., ASM #2 informed this cility could not find any so. When asked where they SM #2 stated in the HR files. ASM #2 stated, "We st night and can't find m. 9/6/17 m. 5/28/15 m. 8/21/17 m. 3/5/12 m. 3/14/16 m. 8/11/11 m. 5/12/14 m. 7/22/08 m. 4/2/15 on 2/1/18. The reformance Appraisal documented in part, "Policy: with their regular full-time, ir regular casual employees at duct a performance education will be provided | F 73 | 3. Education provide to Facil Leadership by the Regional Human Resource Director policy and regulation for completing annual performation reviews for staff. 4. Human Resources to commonthly audit to assess for requiring annual performation based on their hire Variances will be corrected when observed and brough Quality Assurance and Performance Improvement Committee monthly with QAPI Committee responsition ongoing compliance. 5. Date of Compliance: 3/15 | mance plete or staff ance e date. d ght to nt the |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING __ C 495246 B. WING 02/07/2019

| STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
|--|---|--|--|
| EFIX (EACH CORRECTIVE ACTION SHOULD BE | COMPLETIC DATE | | |
| F 730 | | | |
| F 732 1. Staff Posting was corrected on 2/07/19 to reflect actual hours worked per regulation. 2. All patients are at risk for incomplete staff posting information. 3. Center Executive Director, Director of Nursing, Nurse Practice Educator, or designee will educate scheduler and shift supervisors on regulation for required daily posting, to include recording the actual hours worked. | | | |
| PR | F 732 F 732 F 732 1. Staff Posting was corrected on 2/07/19 to reflect actual hours worked per regulation. 2. All patients are at risk for incomplete staff posting information. 3. Center Executive Director, Director of Nursing, Nurse Practice Educator, or designee will educate scheduler and shift supervisors on regulation for required daily posting, to include recording the | | |

PRINTED: 02/22/201

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | A. BUILDI | TIPLE CONSTRUCTION | | C 02/07/2019 |
|--------------------------|---|---|--------------------|---|--|----------------------------|
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE BE APPROPRIATE | (X5) COMPLETION DATE |
| | §483.35(g)(4) Facilit requirements. The posted daily nurse s 18 months, or as red is greater. This REQUIREMEN by: Based on observati document review, it staff failed to post the hours worked by the licensed and unlicen responsible for resid. The facility staff faile and the actual hours unlicensed nursing s. The finding include: Observation was ma 2/5/19 at approximat posting in the lobby documented the facilibuilding -103, the da documented the folio Shift - Day, Evening, Licensed nursing standing to the facility -3. Unlicensed nursing standing to the facility -3. Observation was ma 2/6/19 at 3:41 p.m. o lobby of the facility. The facility name, the certain standing to the facility of facility name, the certain standing to the facility. The facility name, the certain standing to the facility of the facility of the facility of facility name, the certain standing to the facility of the facility | ty data retention facility must maintain the staffing data for a minimum of quired by State law, whichever T is not met as evidenced on, staff interview, and facility was determined the facility e total number and the actual following categories of sed nursing staff directly tent care per shift. d to post the total number worked by the licensed and staff each day. de during the initial tour on the staff of the facility. The form lity name, the census of the te - 2/5/19. The form further towing: | F | 4. Staff posting will 5 X week by CED designee, then we thereafter, to end information according regulation is inclusively and the second monthly Quality and Performance Improvement Condittee responsions compliant 3/15/2019 | or reekly insure all ording to uded. corrected brought to Assurance mmittee QAPI insible for | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | COM | E SURVEY PLETED |
|---|---|---|-------------------------|---|--|----------------------------|
| | | 495246 | B. WING | | 02 | /07/2019 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZI 11 DAIRY LANE FREDERICKSBURG, VA 2240 | P CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE |
| F 732 | Night - 3. Unlicensed nursing Night - 5. An interview was comember (OSM) #5, 2/6/19 at 3:41 p.m. process for posting usually put up a we write down the staff staff members pick once a day unless asked if this is the found of the staff year ago but was in about one year ago #5 at this time for the weeks of staff postion. The last two weeks received from OSM p.m. All of the pape other two above. The total number of hou An interview was constaff member (ASM specialist, on 2/6/19 | g, Night taff - Day - 5, Evening - 4, staff - Day - 5, Evening - 4, staff - Day - 8, Evening - 8, staff - Day - 9, staff - Day - 9, staff - Day | F | 732 | :NCY) | |
| | scheduler (staffing what is supposed to ASM #3 stated, "The date, the census, the for the day by licen above forms were | ed, "In this building, it's the coordinator)." When asked to documented on the form, the name of the facility, the he breakdown of nursing staff sed and unlicensed staff." The shown to ASM #3. When has properly filled out, ASM #3 | | | | |

PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ 495246 B. WING 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 732 Continued From page 174 F 732 stated, "No, it's should be broken down by RN's (registered nurses), LPN's (licensed practical nurses) and CNA's (certified nursing assistants) and it should be updated each shift. When asked if the number of staff is supposed to be documented, ASM #3 stated, "No, it is supposed to be the number of hours, not staff members." The facility policy, "Posting Staffing" documented in part, "Policy: In accordance with federal and state regulations, (Name of Corporation) will post the census, shift hours, number of staff and total actual hours worked by licensed and unlicensed nursing staff who are directly responsible for patient care for each shift and on a daily basis....2. The posting should include the: a. center name, current date, patient census at the beginning of each shift, center specific shifts, the number and actual hours worked per shift of nursing staff directly responsible for the care of patients. The posting should be: completed on a daily basis at the beginning of each shift and adjusted either upward or downward if staffing changes." Administrative staff member (ASM) #1, the executive director, ASM #2, the nurse executive and ASM #3, were made aware of the above concern on 2/6/19 at 5:32 p.m. No further information was provided prior to exit. Free from Unnec Psychotropic Meds/PRN Use F 758 F 758 SS=D CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.

§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|--|---|----------------------------|
| ALLE OF F | CONTROL OF OURDING | 495246 | B. WING | | | 2/07/2019 |
| NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 175 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-psychotic; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic | | ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY) | | HOULD BE | (X5) COMPLETION DATE |
| | | | F 758 | 1. Resident #61 PRN L was re-assessed by Practioner on 2/11, discontinued. 2. 100% audit of all curesidents on antian medications was conversing Leadership that there were no residents with as manxiolytic medication longer that the sum of the | Nurse /2019 and urrent exicty ompleted by to ensure other eeded ons for a an 14 days. in-service eursing staff sary cations, to ytic not be ered for s without sician for | |
| | | | 1 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE O | ONSTRUCTION | (X3) DAT | E SURVEY MPLETED C |
|--------------------------|--|--|---------------------|--|---|----------------------------|
| | over district of the | 495246 | B. WING | LE Chief Colonia Colon | 02 | 2/07/2019 |
| | PROVIDER OR SUPPLIER | | 11 0 | REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| | drugs are limited to renewed unless the prescribing practitic the appropriatenes. This REQUIREMED by: Based on staff interes and facility docume failed to ensure one free of unnecessary. Resident #61 had a Lorazepam (1) more stop date. The Findings Included fat/cholesterol in the disease (2), and Derecent Minimum Dawas a 14-Day Asser. Reference Date (AF #61 was scored as Mental Status (BIMS impairment. Resident total assistance of the transfers and toileting person for ambulatic two or more people extensive assistance bed mobility, and hy A review of the Physical Physic | o 14 days and cannot be a attending physician or oner evaluates the resident for so of that medication. NT is not met as evidenced erview, clinical record review, entation review, facility staff a resident, Resident #61, was a psychotropic medications. PRN (as-needed) order for than 14 days old and with no led: Ided: I | F 758 | 4. Director of Nursing and designee to complete 1 audit of new orders 5X four weeks, and weekly thereafter, for orders for as needed anxiolytic medications to ensure stop date/evaluation days or less included in order. Variances will be provided to Physician/N Practioner for correction brought to Quality Assurant Performance Improcementates monthly with Committee responsible ongoing compliance. 5. Date of Compliance: 3/ | week for for "prn" that a ate of 14 the e Nurse on and urance ovement th QAPI for | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | co | TE SURVEY MPLETED C 02/07/2019 | | |
|--|--|---|--------------------|--|---|----------------------------|
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA 11 DAIRY LANE FREDERICKSBURG, VA | TE, ZIP CODE | 20112019 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECT CROSS-REFERENCE | PLAN OF CORRECTION ITVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY) | (X5) COMPLETION DATE |
| F 758 | labeled "date", 01/20 the order, the colum was left blank. A review of Resident Administration Recoreceived the PRN do 2nd, 2019. On 02/07/2019 at 1:: conducted with ASM Member) #5, the Nurasked to describe with prescribed Ativan. Sused to treat anxiety sometimes used in puberaviors", but that When asked about with place when prescrib #5 stated that, aside the resident's allergial Ativan are usually with schedule. She stated for one to be given "written for greater the state that if the prescresident needs the meded for more that the that if the prescresident needs the meded for more that the state that if the prescresident needs the meded for more that the prescresident needs the meded for more that the prescresident needs the more ded for more that the prescresident needs the more ded for more that the prescresident needs the more ded for more that the prescresident needs the more ded for more that the prescresident needs the more ded for more that the prescresident needs the more ded for more that the prescresion of th | 0/19 was typed. To the right of n labeled "Discontinue by" | F | 758 | | |

| 11-11-11 | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | (X2) MULTIF A. BUILDING B. WING | | |
|--------------------------|--|--|---------------------------------------|---|-------------------|
| | ROVIDER OR SUPPLIER | | 15 THE 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FICIENCY) | JLD BE COMPLETION |
| F 758 | to treat agitation of went on to state the from the hospital will place, he usually lebecause many resist to their new environmential anxiety medical maximum time he days. After that, he medication or ask resident and decide extended. When a described the initial ASM #3 responder A review of the fact Psychotheraputic following under the ensure patients and drugs for approprial engths of treatments. | y cases, the hospital does this r disruptive behaviors. ASM #3 at for these residents arriving with a PRN order already in eaves it in place at the facility idents have difficulty adjusting ament and can benefit from ation. ASM #3 stated that the uses the as-needed order is 14 e will either discontinue the Psychiatric services to see the le if the medication should be sked, if, in either case, al order should only be 14 days, d, "yes, that is correct." Cility policy "3.9 Medication Use" revealed the e heading "Purpose": "To e prescribed psychotherapeutic ate indications, dosages, nt, and duration." | F 75 | 58 | |
| | The Executive Directive Directive Directive Directive, Andrews Executive, Andrews Executive, Andrews Executive, Andrews Executive, Andrews Executive Directive Directi | ector, ASM #1and Center ASM #2, were informed of the d of Day Meeting on rther information was provided. sed to relieve anxiety. class of medications called It works by slowing activity in | | | |

PRINTED: 02/22/2019 FORM APPROVE

OMB NO. 0938-039

| CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 200 | | | PLETED |
|---|---|---|--|--|---|
| | 495246 | 8. WING | | l . | C 07/2019 |
| NT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | 02 | 07/2019 |
| (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SI | HOULD BE | (X5) COMPLETION DATE |
| 2. Alzheimer's diseat form of dementia ar is a brain disorder the person's ability to calce begins slowly. It first brain that control the People with AD may things that happened they know https://medlineplus. Nutritive Value/Apper CFR(s): 483.60(d) (food an Each resident receives 483.60(d) (food conserve nutritive vestas.60(d) (food attractive, and at a stemperature. This REQUIREMENT by: Based on observatinterview, facility do determined that the food was palatable funch meal on 2/5/1 on 2/5/19, the facility a palatable taste and Unit. The findings included on 02/05/19 at 11:00 on 02/ | ase (AD) is the most common nong older people. Dementia nat seriously affects a sarry out daily activities. AD to involves the parts of the bought, memory and language. It have trouble remembering and recently or names of people gov/alzheimersdisease.html ear, Palatable/Prefer Temp (1)(2) and drink was and the facility provides-prepared by methods that alue, flavor, and appearance; and drink that is palatable, safe and appetizing. It is not met as evidenced ion, resident interview, staff cument review, it was facility staff failed to ensure on one of four units during the 9. Ity staff failed to serve food at d temperature on the Martin experience on the Martin experience. | | | | |
| | | | | | |
| | ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page 2. Alzheimer's diseast form of dementia are is a brain disorder the person's ability to cate begins slowly. It first brain that control the People with AD may things that happened they know https://medlineplus. Nutritive Value/Apper CFR(s): 483.60(d) Food an Each resident received shallow food attractive, and at a stemperature. This REQUIREMENT by: Based on observation of the food was palatable food was palatable food was palatable food the food was palatable food was palatab | A95246 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 179 2. Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. AD begins slowly. It first involves the parts of the brain that control thought, memory and language. People with AD may have trouble remembering things that happened recently or names of people they know https://medlineplus.gov/alzheimersdisease.html Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, it was determined that the facility staff failed to ensure food was palatable on one of four units during the funch meal on 2/5/19. On 2/5/19, the facility staff failed to serve food at a palatable taste and temperature on the Martin | A BUILDING 495246 8. WING ROVIDER OR SUPPLIER NT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 179 2. Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. AD begins slowly. It first involves the parts of the brain that control thought, memory and language. People with AD may have trouble remembering things that happened recently or names of people they know https://medlineplus.gov/alzheimersdisease.html Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) \$483.60(d) Food and drink Each resident receives and the facility provides-\$483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, it was determined that the facility staff failed to ensure food was palatable on one of four units during the lunch meal on 2/5/19. On 2/5/19, the facility staff failed to serve food at a palatable taste and temperature on the Martin Unit. The findings include: On 02/05/19 at 11:00 a.m., a group interview was | ROWIDER OR SUPPLIER NT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 179 2. Alzheimer's diseases (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities. AD begins slowly. It first involves the parts of the brain that control thought, memory and language. People with AD may have trouble remembering things that happened recently or names of people they know https://medlineplus.gov/alzheimersdisease.html Nutritive Value/Appear, Patatable/Prefer Temp CFR(e): 483.60(d)(1)(2) \$483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; \$483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, it was determined that the facility staff failed to ensure food was palatable taste and temperature on the Martin Unit. The findings include: On 02/05/19 at 11:00 a.m., a group interview was | A BUILDING A STREET ADDRESS, CITY, STATE, 2IP CODE TO PROVIDERS PLAN FOR CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (ECA-FDEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 179 2. Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out delily activities. AD begins slowly. It first involves the parts of the brain that control thought, memory and language. People with AD may have trouble remembering things that happened recently or names of people they know https://medlineplus.gov/alzheimersdisease.html Nutritive Value/Appear, Palatable/Prefer Temp CFK(s): 483.60(d)(1) Food and drink Each recives and the facility provides-s483.60(d)(1) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. S483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Sased on observation, resident interview, staff interview, facility document review, it was determined that the facility staff failed to ensure food was palatable on one of four units during the funch meal on 2/5/19. On 2/5/19, the facility staff failed to serve food at a palatable taste and temperature on the Martin Unit. The findings include: On 02/05/19 at 11:00 a.m., a group interview was |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 180 of 20



| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION | (X3) DATI | E SURVEY PLETED C |
|--------------------------|--|---|-----------------------------------|---|---|----------------------------|
| 8 | PROVIDER OR SUPPLIER | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405 | 1 02 | /07/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD 8E | (X5) COMPLETION DATE |
| | voiced complaints hot." On 02/05/19 at 11: made of the tray lir complaint investiga always hot." At app tray consisting of a tots, mash potatoes grilled cheese sand cart with the lunch sent to the Martin U (other staff member manager, followed approximately 1:55 served to a resident 7 was asked to refood cart, placed it proceeded to take to OSM #7 was obserfood temperatures (Fahrenheit), tater the grilled cheese (Fahrenheit), tater the grilled cheese sandwich was 116 co OSM #7 sampled tholding temperature asked to describe the cheese sandwich Otaste." When asked to the food before it is #7 stated no. On 02/06/19 at 1:32 conducted with OSM When asked about the food before it is when asked about the food before it is #7 stated no. | that the food "is not always 55 a.m., observation was ne in the kitchen based on a ation that the food "is not proximately 1:35 p.m., a test grilled cheese sandwich, tater s, tomato soup and pureed dwich was placed in the food trays for residents' and was Jnit. This surveyor and OSM r) #7, dining services | F 804 | Dietary staff in services Food Quality and Palat Dietary Services Manage focusing on appropriate line temps and tasting before serving, to inclus appropriate consistence pureed diets by 3/1/20 All patients are at risk for not at appropriate temperatures. Dietary Manager/Design complete test trays 5x for 4 weeks, then 2x perfor 6 weeks to ensure appropriate temperature palatability at point of Administrator or design audit a test tray of reguland pureed diet 3 X were four weeks then random thereafter to ensure palatability. Variances will be correct immediately, document brought to monthly Quinter and pure diet of the palatability. | ability by ger e tray food de y of 19. for foods anee to per week er week res/ and service. hee will lar diet ek for mly cted ted and | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/20 FORM APPROVE OMB NO. 0938-039

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|--------------------------|--|-------------------------------|
| | | 495246 | B. WNG | 9. | C 02/07/2019 |
| | PROVIDER OR SUPPLIER | | , | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | 02/0//2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE COMPLETION |
| SS=E | point of service." Whe taste and flavor of the # 7 stated, "I could tell temperature, it tasted thought it was appealis stated, "Most likely no upon." The facility policy, "For documented in part, "For methods that conserve appearance. Food will and served at a safe a temperature." Food Procurement, Sto CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety The facility must - §483.60(i)(1) - Procure approved or considered state or local authoritie (i) This may include foo from local producers, signal local laws or regulated (ii) This provision does facilities from using progardens, subject to consafe growing and food-liii) This provision does | en asked to describe the pureed grilled cheese OSM lit wasn't at the correct gummy." When asked if he ng to the residents OSM # 7 t. It could be improved but the could be improved but the could be improved but the prepared by a nutritive value, flavor, and it be palatable, attractive and appetizing bre/Prepare/Serve-Sanitary requirements. food from sources disatisfactory by federal, s. and items obtained directly subject to applicable State ations. In the prohibit or prevent duce grown in facility appliance with applicable handling practices. In the procured by the facility. The procured by the facility applicable and the with professional ce safety. | F 812 | Assurance and Performance Improvement Committee monthly with QAPI Commit responsible for ongoing compliance. 5. Date of compliance: 3/15/2 | ittee |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 182 of 206



| AND PLAN OF CORRECTION IDENTIFICATION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | E CONSTRUCTION | The second secon | ATE SURVEY DMPLETED |
|---------------------------------------|---|--|---------------------|--|--|----------------------------|
| Market Comment | | 495246 | B. WING | | Part Comment | 02/07/2019 |
| | PROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | TO BE TO AREA |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 812 | Based on observat document review it facility staff failed to food in a sanitary in 1. The facility staff tartar sauce and so 2. The facility staff meat slicer in a clear substance of the foodplace clean soup by serving. The findings include 1. The facility staff tartar sauce and so On 02/05/19 at 9:15 kitchen was conduct member) # 7, dining Observation of the irefrigerator revealed containers with approximate the containers with approximate the containers of the irespective of the | tion, staff interview, and facility was determined that the obstore, prepare and serve manner. failed to label containers of our cream with a use-by date. failed to maintain a mixer and an and sanitary manner. failed to keep used alcohol preparation sheet pan and owls on a clean surface before as: failed to label containers of ur cream with a use-by date. failed to label containers of ur cream with a use-by date. failed to label containers of ur cream with a use-by date. failed to label containers of ur cream with 2 small plastic roximately two ounces of a container and three plastic roximately two ounces of sour Further observation of the | F 812 | F812 1. The slicer and mixed cleaned immediated to use. The items in labeled properly with disposed of immediated properties of the Dining Services Directly of the Directly of the Dining Services Directly of the Dining Services Directly of the Dining Se | ely prior not ere liately by ector. serviced ctor on tizer erly and ating & roper use I swabs, owls n clean on | |

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|-----------------------------------|--|-------------------------------|
| | PROVIDER OR SUPPLIER | | ST 11 | REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE REDERICKSBURG, VA 22405 | 02/07/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETIC |
| F 812 | "25. Use-By Dating marked with the ma are properly stored or long as the product any other food or prepared or portione established." On 02/06/19 at appreciate (administrative staff director, and ASM #2 made aware of the analysis of the material street of the analysis of the material street of th | Guidelines. Foods that are nufacturer's 'use-by' date that can be used until that date as has not been combined with epared in any way including a product has been ed, a new 'use-by' date is oximately 5:50 p.m., ASM member) #1, the executive 2, executive nurse, were above findings. In was provided prior to exit. In ailed to maintain a mixer and an and sanitary manner. In a.m., an observation of the ed with OSM (other staff services manager. In ailed to maintain a mixer and the analysis of the mixer was use OSM # 7 stated, "Yes." The ed the bag covering the vation of the mixer revealed don the splashguard of the nig bowl and food debris pins for the cage. OSM # 7 | F 812 | 3. Dietary Manager to complete daily audits of kitchen sanitation 5 x proved week for 6 weeks to enslicer and mixer cleaned and stored properly, prodating and labeling, profuse and disposal of alcoswabs, and soup bowls being used properly on clean surfaces. 4. Administrator and Registered Dietician to audit the kitchen weekly for Sanitation requirements to ensure in compliance with regulation. Variances will be corrected immediately and brought monthly Quality Assurance and Performance Improvement Committee monthly with QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 3/15/2019 | per sure di opper per hol |

PRINTED 02/22/2019 FORM APPROVED OMB NO. 0938-039'

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A, BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
|---|--|--|----------------------------|----------|--|-------|----------------------------|
| | | 495246 | B. WING | | | 0: | C 2/07/2019 |
| | ROVIDER OR SUPPLIER | ¥ | i | 11 DAIRY | ADDRESS, CITY, STATE, ZIP CODE LANE RICKSBURG, VA 22405 | | = 900 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 812 | the base under the gradice deflector. OSM the debris on the medebris was food debrated in the surrounding environment on the surrounding environment on the kitchen. Slicer was not clean. On 02/06/19 at 1:32 conducted with OSM the meal slicer and moSM # 7 stated, "It is sanitized after each use a sanitized after each use of the cleaned and so the cleaned and so the cleaned and so the cleaned aware of the allow further informations. The facility staff facts as the conduction of the facility staff facts and the cleaned aware of the allow further informations. The facility staff facts as the conduction of the facility staff facts and the cleaned and so the cleaned aware of the allow further informations. The facility staff facts and the conduction of the facility staff facts and the cleaned and the cleaned aware of the allowed the cleaned aware of the cleaned the cleaned aware of the cleaned t | auge plate and under the # 7 was asked to observe at slicer. When asked if the is, OSM # 7 stated he could bod debris or debris from the nent where work had been OSM # 7 agreed the meat p.m., an interview was # 7. When asked how often nixer should be cleaned, hould be washed and use." quipment" documented in All food contact equipment anitized after every use." eximately 5:50 p.m., ASM member) #1, the executive t, executive nurse, were | F | 312 | | | |
| TI . | made of the holding the steam table revealed the end and in line work observation of the forevealed a sheet par | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 185 of 20



| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|---|--|---------------------|--|--------------------------------|------------------------------|--|
| | | 495246 | B. WING_ | | | 02/07/2019 | |
| | NT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | DDE | | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 812 | parchment paper. was a stack of slice and a small stack ready for grilling. member) # 11, the temperatures reve alcohol swab pack after taking the ter and set the used a that contained the grilled cheese san of the tray line rev placing six clean s food preparation to Further observatio preparation table a was not cleaned b placed there and t bowls. Further ob service revealed 0 the six soup bowls soup, and placing and then placing to trays." On 02/05/19 at 2:2 conducted with Os manager. When in the placement of t clean soup bowls, should have been the food prep (pre clean soup bowls clean serving tray. | on the pan was covered with On top of the parchment paper ed cheese, 12 slices of bread, of 4 grilled cheese sandwiches Observation of OSM (other staff cook taking the food aled that she would open an tage, clean the thermometer inperature of each food item alcohol swabs on the sheet pan cheese, bread and prepped dwiches. Further observation ealed a kitchen staff member oup bowls, upside down on the able above the sheet pan. In of the area on the food above the sheet pan revealed it efore the soup bowls were here was food debris under the servation of the food line DSM # 11, the cook, picking up to the cook, picking up to the cook of the months and the servation of the observation of the OSM # 7, dining services informed of the observation of the used alcohol swabs and the OSM # 7 stated, "The swabs placed in the trash and not on paration) sheet pan and the should have been placed on a " | F8 | | | | |
| _ | documented in pa | 'Food: Preparation" rt, "2. Dining Services staff will food preparation that avoid | | | | | |

| | ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED C 02/07/2019 | | |
|--------------------------|--|---|--|--|---------------------------------------|
| | PROVIDER OR SUPPLIER | | 111 | REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405 | 1 020112019 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION |
| | contamination by pand chemical contamination by pand chemical contamination of the contaminat | protentially physical, biological amination." proximately 5:50 p.m., ASM off member) #1, the executive #2, executive nurse, were above findings. ion was provided prior to exit. and Refuse Properly sose of garbage and refuse NT is not met as evidenced tion and staff interview, it was a facility staff failed to maintain in a sanitary manner. ed to close the sliding doors dumpsters and maintain the mpsters free of trash. | F 814 | Dumpster area was cleane immediately by Environmes Services Director and staff 2/5/19. Environmental Service, Die and Maintenance Staff alor with center management to Members were in serviced CED, Nurse Practice Educat Maintenance Director, Environmental Services Manager and Dining Services Director on cleaning around entire dumpster and keepin doors closed according to regulation on 2/5 and 2/6/2019. All patients are at risk for garbage not being disposed properly. Housekeeping and Dietary Manager or designee to monitor dumpster 5x weefor 6 weeks and weekly thereafter to ensure no deb surrounding dumpster and | ental on Itary ng eam by or, es d ng |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | 1, , | TE SURVEY MPLETED |
|--------------------------|--|---|------------------------------|--|---|----------------------------|
| | | 495246 | B. WNG | | | C |
| | PROVIDER OR SUPPLIER | | 11 | REET ADDRESS, CITY, STATE, ZIP O DAIRY LANE REDERICKSBURG, VA 22405 | | 2/07/2019 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE | ION SHOULD BE 'HE APPROPRIATE | (X5) COMPLETION DATE |
| | located on the side Further observation two dumpsters reverapproximately three approximately four old plastic trash bag one of the shrubs. covers, numerous p Styrofoam cups, se plastic cups, approximately four plastic cups, approximately four plastic gloves and s An interview was the and # 7. When ask keeping the dumpst maintaining the dum "Environmental service checking the dumps on Thursdays and biduring the rest of the all the debris and tra dumpsters, OSM # 1 care of it the other did animals around it and them." OSM # 7 sta and the sides of the about the sliding dood the dumpster, OSM # 3 doors should be kep On 02/06/19 at approximately made aware of the a | was open on each dumpster. In of the lawn area behind the saled the following: It old clear plastic trash bags, soda cans and bottles, a clear ghanging from a branch in Approximately 24 plastic bowl bieces of paper, several everal plastic spoons and cimately four pairs of used everal plastic straws. It is conducted with OSM # 1 and who was responsible for er's door closed and apsters in a clean and sanitary and # 7 stated they were. The transfer of the procedure for apsters, OSM # 1 stated, sices is responsible for ters on Tuesdays and dietary oth department monitor it as week." When asked about also observed behind the lastated, "I was going to take any but there were some delidin't want to deal with the ded, "I always check the front dumpsters." When asked for seeing open on the sides of the closed." Deximately 5:50 p.m., ASM member) #1, the executive executive nurse, were | F 814 | doors closed. A designee to mor for debris and de week for 4 week thereafter. Resu audits will be bre the Quality Assu Performance Im Committee mon QAPI Committee for ongoing com 5. Date of complian | nitor dumpster oors closed 3 x as then weekly ults of these ought before rance and provement thly with the responsible pliance. | |

| | The state of the s | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|--|--|--|
| | 495246 | | B. WNG | B. WNG | | |
| | PROVIDER OR SUPPLIER ONT CENTER | - AT - | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLE | |
| | CFR(s): 483.20(f)(5), 4 §483.20(f)(5) Resident (i) A facility may not re- resident-identifiable to (ii) The facility may rele- resident-identifiable to accordance with a con- agrees not to use or di except to the extent the to do so. §483.70(i) Medical rece- §483.70(i)(1) In accord professional standards must maintain medical that are- (i) Complete; (ii) Accurately documer (iii) Readily accessible; (iv) Systematically orga- §483.70(i)(2) The facility all information container regardless of the form of records, except when re- (i) To the individual, or the representative where per (ii) Required by Law; (iii) For treatment, paymoperations, as permitted with 45 CFR 164.506; (iv) For public health act neglect, or domestic viol activities, judicial and ad aw enforcement purpos purposes, research purp | dease information that is the public. ease information that is the public. ease information that is an agent only in tract under which the agent sclose the information e facility itself is permitted end. each with accepted and practices, the facility records on each resident enter the resident's records, or storage method of the elease isheir resident ermitted by applicable law; ent, or health care by and in compliance ence, health oversight ministrative proceedings, es, organ donation oses, or to coroners, ral directors, and to avert | F 84 | 1. Resident #312 composer plan for incorred of dementia was distributed administered late or and 10/3/18, Resided 31 clinical record diddemonstrate details Late entry document made to resident #3 for the falls that had 2. All residents are at inaccurate medical 100% residents who themselves out on absence have been ensure that measure to administer their recording to order. residents who have the last 30 days were to ensure document place regarding the and follow up to the 100% of care plans for currently in the facility audited including endiagnosis used are according used are according to severe document place regarding the and follow up to the 100% of care plans for currently in the facility audited including endiagnosis used are according used are according to severe document place regarding the and follow up to the 100% of care plans for currently in the facility audited including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are according to severe document place including endiagnosis used are acco | ect diagnosis scontinued, ations were n 8/30/18 ent #39 and d not so of falls. Atation were 39 and # 31 di occurred. Fisk for records. To sign leave of reviewed to ses are taken medications All had falls in the reviewed tation in actual fall event. For residents ity were suring the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED C 02/07/2019 | | | |
|--|--|---|--|--|--|----------------------------|
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| | by and in compliant §483.70(i)(3) The firecord information in unauthorized use. §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requiren (iii) For a minor, 3 y legal age under State §483.70(i)(5) The minor (ii) A record of the minor (iii) The comprehens provided; (iv) The results of an and resident review determinations cond (v) Physician's, nursy professional's progressional's progressional's progressional's progressional from the services reports as in this REQUIREMEN by: Based on staff interreview, and clinical in course of a complain determined the facilii complete and accurate 55 residents in the signal in the sign | ce with 45 CFR 164.512. acility must safeguard medical against loss, destruction, or sal records must be retained are required by State law; or the date of discharge when then in State law; or ears after a resident reaches the law. The dical record must containation to identify the resident; assessments; sive plan of care and services and preadmission screening evaluations and flucted by the State; e's, and other licensed ass notes; and other diagnostic required under §483.50. This not met as evidenced wiew, facility document ecord review and in the attinvestigation, it was the staff failed to maintain a late clinical record for four of curvey sample, Residents #31. | F8 | 3. Nurse Practice Educe and or designee to licensed nursing state accurate care plan documentation, late administration of mand complete documentation falls. 4. ADON and or design 20% of care plans weeks to ensure according to ensure proper documentation for leadministration and a residents who fall 50 four weeks, to ensure complete clinical recording to ensure documentation. All a be continued weekly Results of audits will reviewed at Quality A and Performance Implementation committee monthly committee responsibility ongoing compliance. 5. Date of Compliance: | in-service iff on e ledication mentation reference to lee to audit reekly for 4 curacy, 20% or 4 weeks late ludit X week for re ord ludits will thereafter. be Assurance provement with QAPI ole for | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | LE CONSTRUCTION | | COMPLETED COMPLETED C 02/07/2019 | |
|---|---|--|--|---|-----------|-------------------------------------|--|
| | ROVIDER OR SUPPLIER | 495246 | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 842 | clinical record for medications to Redocumented two resident #35 a 10/3/18, when the resident was out of the resident with the resident was of the resident with the resident was of the resident #312 work of the resident | if failed to ensure an accurate the administration of sident #35. The facility staff medications were administered to 8:00 p.m., on 8/30/18 and clinical record documented the of the facility. If failed to evidence that the sumented the details of Resident 18, 12/24/18, 1/1/19, 1/6/19, If failed to evidence that the sumented the details of Resident 1/18 and 1/18/19. If failed to evidence that the sumented the details of Resident 1/18 and 1/18/19. If inaccurately documented imprehensive care plan with a centia. It is a sadmitted to the facility on gnoses that included but were umonia, fracture (break) of right any tract infection (2), dysphagia, | F 842 | | | | |
| 000 1000 1000 1000 1000 1000 1000 1000 | data set), an adm (assessment refe Resident # 312 as brief interview for of 0 - 15, (11) ele of cognition for m # 312 was coded | most recent MDS (minimum ission assessment with an ARD rence date) of 08/06/18, coded is scoring an (11) eleven on the mental status (BIMS) of a score wen - being moderately impaired aking daily decisions. Resident as requiring limited assistance per for activities of daily living. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 10 | IPLE CONSTRUCTION | | TE SURVEY MPLETED | |
|---|---|---|---|---|------------------------------|----------------------------|--|
| | | 495246 | B. WING_ | | | 2/07/2019 | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | 02/01/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 842 | dated 07/30/2018 Resident/patient Infunction or impaired a condition other of than Alzheimer's condition other of than Alzheimer's condition other of than Alzheimer's condition of the male admitted ocumented, "(Resold) female admitted with Pneumonia. Diagnosis: Pneumonia. Diagnosis: Pneumonia. Diagnosis: Pneumonia. Diagnosis: Pneumonia. Diagnosis: Pneumonia. Tract infection), Fartery disease), Dhyperlipidemia, and fracture." The "Assessment (Name of Hospital documented, "(Intellipidemis: Diarrhed due to infectious of a 93 y.o. (year old medical history) of diabetes mellitus, who presents here accompanied by a secondary to fever the facility's POS "7/30/18" for Residential processing the proposition of the | ve care plan for Resident # 312 , documented, "Focus: as impaired/decline in cognitive ed thought processes related to than delirium: Dementia (other disease). Date initiated: & Plan" dated 07/25/18 from d) for Resident # 312 esident # 312) is a 93 y.o. (year ted under the hospitalist service Patient Active Problem List: tonia, Diarrhea, UTI (urinary tillure to Thrive, CAD (coronary tillure to Thrive, CAD (coronary tillure to Thrive, hypertension, and recent right humerus & Plan" dated 07/28/18 from d) for Resident # 312 ernal Medicine Daily Progress roblem" Pneumonia. Active ea, Pneumonia left lower lobe organism. "(Resident # 312) is d) female with a PM Hx (past f coronary artery disease, hypertension, hyperlipidemia te from assisted living facility multiple family members | F | 342 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | IDENTIFICATION NUMBER: | 111 10.5WSB2-1/9 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED C 02/07/2019 | |
|---|---|--|---------------------|--|--------------------------------|--|--|
| | NT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | DDE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 842 | (clostridium difficile (right) humerus fx Further review of t 312 failed to evide diagnosis of deme On 02/07/19 at 11: conducted with RN coordinator and Lf 6, MDS nurse. LP diagnosis of deme comprehensive ca came from. RN # clinical for Reside not documented a plan is inaccurate dementia. When to (who was no long the initial care plan dementia on the cashe got that diagnoses from summary and any hospital." On 02/07/19 at ap (administrative stadirector, and ASM made aware of the References: | he clinical record for Resident # nce documentation of a ntia. 21 a.m., an interview was N (registered nurse) # 6, MDS N (licensed practical nurse) # N #6 was asked where the ntia documented on the re plan for Resident # 312 and LPN # 6 reviewed the nt # 312. RN # 6 stated, "It is nywhere else, then the care in terms of the diagnosis of the assistant director of nursing employed with the facility) did n, she put the diagnosis of are plan. I don't know where osis from." When asked to less for obtaining a resident's and LPN # 6 stated, "We get m the hospital discharge other information from the approximately 3:45 p.m., ASM aff member) #1, the executive i #2, executive nurse, were e above findings. ation was provided prior to exit. | F 5 | 842 | | | |

PRINTED: 02/22/2019 FORM APPROVEL OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|--|--------------------------------|-------------------------------|--|
| | | 49 5246 | B. WING | | 0: | C 2/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION) | ID PREFI TAG | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 842 | shoulder. This inforwebsite: https://www.healthl merus-bone#1. (2) An infection in t information was ob https://www.nlm.nil 000521.htm. (3) A swallowing di obtained from the v https://www.nlm.nil sorders.html. (4) Low potassium the amount of pota than normal. This the website: https://medlineplus 2. The facility staff clinical record for ti medications to Res documented two m to Resident #35 at 10/3/18, when the resident was out or Resident #35 was 5/22/18 with the di hip fracture, atrial of falls, inguinal herni most recent MDS of quarterly assessm Reference Date) of coded as being co daily life decisions | etween the elbow joint and the rmation was obtained from the line.com/human-body-maps/hu the urinary tract. This stained from the website: h.gov/medlineplus/ency/article/sorder. This information was website: h.gov/medlineplus/swallowingdi level is a condition in which assium in the blood is lower information was obtained from s.gov/ency/article/000479.htm. failed to ensure an accurate the administration of sident #35. The facility staff nedications were administered 8:00 p.m., on 8/30/18 and clinical record documented the | F | 842 | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 194 of 20



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | FIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--------------------|-------------------------------------|------------------------------|-------------------------------|--|
| | | 20 11 | 55: 101 | | | С | |
| | | 495246 | B. WING_ | - 11 | | 02/07/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | Wi 11 | STREET ADDRESS, CITY, STATE, ZIP CO | DE | | |
| | | | | 11 DAIRY LANE | | | |
| WOODMO | NT CENTER | | | FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 842 | Continued From page | ge 194 | F | 842 | | | |
| | dressing, eating, an supervision for hygi | d toileting and as requiring ene. | 10 | | | | |
| | physician's order da | cal record revealed a sted 8/22/18 that documented on LOA [leave of absence] | | | | | |
| | A review of the nurs following: | e's notes revealed the | | 33 | | | |
| | "Resident signed ou that he was going to going to church toni contacted at 10pm to not back at facility. contacted. Residen soon after and was | d 8/30/18 documented, ut at 1:30pm, today and stated to (name of bank) and not light. Cousin and friend were today because resident was Unit manager on call was at made contact with facility reported to unit manager on will pick up resident from ation)" | | E4 | | | |
| | entry: This RN was residents failure to this departure for the Nursing staff was at RP to see if they kn located. This RN with made with residents which knew of his with notified of incident. Call the sheriffs offic report the residents approximately 10:30 staff that (resident) stated he was at the get back due to not | d 8/31/18 documented, "Late contacted by nursing staff of return to the facility following a bank earlier in the afternoon. dvised to make contact with ew where resident was as advised that contact was a cousin and friend, neither of whereabouts. DON was Nursing staff was advised to be non emergency number to failure to return. At Dpm, this RN was notified by had called the facility and a Firestone and was unable to having enough money for the er went to pick up resident | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: A. BUILDI | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
|--|--|---|--|-----------|------------------------------|--|
| | 495246 | B. WING | Samuel Control of the | 0 | 2/07/2019 | |
| NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| Firestone (location) s Resident stated he le facility and was unab Resident returned to the importance to the timely manner and th evening medicine. R understanding. Resi usually goes when he another incident occu Resident stated that bank) on (location) a center above or belor returned to facility at supposed to return b facility at 7:50 p.m., t Station in (location) v returned at 9:30 p.m. the Bus Station gave education given on S out alone he must he ways and he must re A review of the clinic dated 5/23/18 for Ca daily for calcium sup {2} 50 mg (milligrams pressure. A review of the Augu Administration Recor resident was to recei 8:00 p.m. On 8/30/1 initialed and docume | nt was found in front of the itting on the ground. If his bank card back at the le to get a ride back. facility. This RN stressed resident of returning in a see need to be able to take his desident expressed dent was asked where he le leaves the facility so if curs we know where to look, the goes to the (name of and is usually in the shopping with the hospital. Resident approximately 11:30pm." 10/3/18 documented, 12:10 p.m., for LOA was by 6:10 p.m., Fatient called to say he was at the Bus with no way back. Patient are a ride back." Patient cafety and if Patient is going are money for Cab fare both | F 842 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDIN | TIPLE CONSTRUCTION NG | | OMPLETED |
|--------------------------|---|---|---------------------|--|--------------------------------|----------------------------|
| 建工 经经济 | SHIMING OF ST | 495246 | B. WING_ | | | 02/07/2019 |
| | NT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | DDE | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 842 | resident was not p | resent in the building between | F8 | 342 | | |
| Å | | 30 p.m. There was no shysician was notified, as to administer the | | | | |
| | that the resident was medications above these medications | tober 2018 MAR documented as to receive the same two at 8:00 p.m. On 10/3/18, were initialed and documented 8:00 p.m., when the nurses' | | | | |
| | notes, documented in the building betw There was no evid | If the resident was not present ween 2:10 p.m. and 9:30 p.m. ence that the physician was for orders to administer the | V | | | |
| | #4, was asked abo when a resident is miss medications. | o.m., in an interview with LPN out the process staff follows out on leave long enough to LPN #4 stated the physician overify if the medications could | | | | |
| į. | conducted with the | o.m., an interview was Executive Director (ASM ff member] #1) and Nurse | | | | |
| | resident's unsuper community and iss | 2. When asked about the vised outings into the sues he had of returning to the latest that he was alert | | | | E |
| | and oriented, his B Status exam) was stated the physicia | IMS (Brief Interview for Mental a 15 (cognitively intact). She in was aware of the resident's | | | | |
| | wanted to. When missed medication to the facility, ASM | was his right to go out if he asked about the resident's is when he was late returning i #1 stated that the doctor notified and direction provided | | | | - |

| | F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A, BUILDING | E | COMPLETED | |
|--------------------------|---|--|---------------------|--|-------------------|--|
| | | 495246 | B. WING | | C 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | 1 0200120 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE COMPLETION | |
| F 842 | | age 197 dminister them (medications) | F 84 | 12 | | |
| | dietary supplement calcium taken in the is needed by the bounder also is understood to be artburn, acid indies available with or Information obtains | id - "Calcium carbonate is a tused when the amount of e diet is not enough. Calcium body for healthy bones, system, and heart. Calcium sed as an antacid to relieve igestion, and upset stomach. It without a prescription." | | | | |
| | combination with o blood pressure. It a (chest pain) and to attack. Metoprolol with other medicati Metoprolol is in a c blockers. It works is slowing heart rate decrease blood pre Information obtains https://medlineplus | ed from .gov/druginfo/meds/a682864.h | | | | |
| | clinical record doci #39's fall on 11/8/1 and 2/3/19. | failed to evidence that the umented the details of Resident 8, 12/24/18, 1/1/19, 1/6/19, | | | | |
| | Resident #39 was | most recently readmitted to the | | | | |

PRINTED: 02/22/2019 FORM APPROVEL OMB NO. 0938-039'

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIE A. BUILDING | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|--|--|----------------------------|--|------------------------------|----------------------------|
| | | 495246 | B. WING_ | | ۰, | 2/07/2019 |
| | ROVIDER OR SUPPLIER | - T | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | 1 0 | 2012019 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLO BE | (X5) COMPLETION DATE |
| F 842 | facility on 12/6/18 wit limited to dementia, of high blood pressure, overactive bladder, a anxiety, and osteoart (Minimum Data Set) with an ARD (Assess 12/3/18. The resider moderately impaired decisions. The reside extensive care for ball eating; and supervisis dressing, and transfer A review of the nurse 11/8/18, which docume condition has been not include: Falls 11/8/18 obtained include: Not note did not docume surrounding the fall, if what, if any, new integrare plan. Subseque following days failed information regarding: A review of the "Ever 11/8/18 documented, room trying to reach stuffed cats. Resident state hurt after a few mins get up from the floor was assessed for an foundInterventions | the diagnoses of but not liabetes, chronic back pain, history of femur fracture, djustment disorder with hritis. The most recent MDS was a quarterly assessment ment Reference Date) of at was coded as being in ability to make daily life ent was coded as requiring thing; limited assistance for on for hygiene, toileting, ars. I's notes revealed one dated mented, "A change in oted. The symptoms in the afternoonOrders NO (no new orders)" This note the circumstances of there were any injuries, and exventions were added to the ent nurses' notes over the to reveal any additional of the details of the fall. It Summary Report" dated ("Resident feel {sic} in dining across the table to get her not fell to floor and hit her end that her head no long {sic} (minutes) and was able to with assistance. Resident y injuries and none were added immediately after fall ed: Resident was educated | F 84 | 42 | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 199 of 20



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--------------------|--|--------------------------------|-------------------------------|--|
| | | 495246 | B. WNG_ | | | C 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | 1D PREFI TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 842 | A review of the nur 12/24/18, which do condition has been include: Falls 12/2 reported to Primary did not document the fall, if there we any, new intervent plan. Subsequent following days faile information regard. A review of the "Ev 12/24/18 document the floor beside he ROM (range of mosigns were taken a initiatedInterven fall and care plan to | se's notes revealed one dated ocumented, "A change in a noted. The symptoms 4/18 in the morningChange by Care Clinician" This note the circumstances surrounding are any injuries, and what, if sions were added to the care nurses' notes over the ed to reveal any additional ing the details of the fall. I went Summary Report" dated atted, "Resident was found on a robed with no injuries, tolerated attion) well with no difficulty, vital | F | 342 | | | |
| | 1/1/19, which documes been noted. The Falls Change report Clinician Orders monitor aware of the circumstances if any, new interventant plan. Subsequent following days fails information regard. A review of the "Evalument of the CNA (Certified). | rse's notes revealed one dated amented, "A change in condition The symptoms include: corted to Primary Care obtained included: Continue to the complaints of buttocks pain at". This note did not document surrounding the fall and what, nations were added to the care nurses' notes over the ed to reveal any additional ling the details of the fall. I went Summary Report" dated d, "The resident was toileted by Nursing Assistant) was all bell when she was done. | | | | | |

PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING C 495246 R WING 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION). CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 842 Continued From page 200 F 842 The resident did not was noted to be lying on the floor near her bed....Interventions added immediately after fall and care plan updated: Staff to remain with the resident while in the bathroom." A review of the nurse's notes revealed one dated 1/6/19, which documented, "A change in condition has been noted. The symptoms include: Falls 1/6/19 in the morning." A second note dated 1/6/19 documented, "....The resident has no new changes in the ROM, usual complaints of general body ache...." A third note dated 1/6/19 documented, "....NP (nurse practitioner)...aware of the falls this am there are no new orders." These notes did not document the circumstances surrounding the fall and what, if any, new interventions were added to the care plan. Subsequent nurses' notes over the following days failed to reveal any additional information regarding the details of the fall. There was no incident report related to this fall provided. A review of the nurse's notes revealed one dated 2/3/19, which documented, "A change in condition has been noted. The symptoms include: Falls in the morning....Change reported to Primary Care Clinician....Orders obtained included: Continued observation...." This note did not document the circumstances surrounding the fall, if there were any injuries, and what, if any, new interventions were added to the care plan. Subsequent nurses'

fall.

notes over the following days failed to reveal any additional information regarding the details of the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | | (X3) DATE SURVEY COMPLETED C 02/07/2019 | |
|---|---|--|-------------------------|--|--|----------------------------|
| 495246 | | | B. WING_ | | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | 210172010 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO TION DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 842 | A review of the "Ev 2/3/19 documente toileted and wante already done by the Assistant). She we had taken her sho she was found in a bed. The resident she was assisted herself up and pla Neuro [neurologic initiatedInterver fall and care plant and encourageme on 2/7/19 at appre Executive Director member] #1) and were made aware that the "Event Su document and is record. At this time legal clinical recorregarding how the any injuries, and it reviews or revision. No further informat the survey. | vent Summary Report" dated d, "The resident had just been of to make her bed which was ne CNA (Certified Nursing anted to place her blankets and es off and her feet slipped and a kneeling position next to her is shoes were placed on and via a gait belt which she pushed ced into her w/c (wheelchair). all checks were nitions added immediately after updated: Continued education ent to be compliant." Eximately 2:20 p.m., the r (ASM [administrative staff the Executive Nurse (ASM #2) of the concern. ASM #2 stated immary Report" is an internal not part of the legal clinical ne, she was notified that the did did not reflect the above data are falls occurred, if there were fiftere were any care plan | F | 342 | | |
| | clinical record dod #31's falls on 12/7 | cumented the details of Resident 7/18 and 1/18/19. | | | | |
| | | admitted to the facility on iagnoses of but not limited to | | | | |

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|--|---|-------------------------------|--|
| 495246 | | | B. WNG_ | | | C 02/07/2019 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | 8. 0 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI) TAG | (EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 842 | high blood pressure, atrial fibrillation, pace contracture, seizures acute kidney failure. (Minimum Data Set) with an ARD (Assess 11/5/18. The resident cognitively intact in a decisions. The resident total care for bathing dressing, toileting an assistance for eating. A review of the nurse 1/18/19, which docur condition has been ninclude: Falls 1/18/1 to Primary Care Clinit document the circum if there were any injuinterventions were as Subsequent nurses failed to reveal any a regarding the details. A review of the "Ever 1/18/19 documented down beside his bed ROM well, res stated something from the fipain/discomfortInterimmediately after fall Educated resident to On 2/7/19 at approxice Executive Director (Assessment). | cardiomyopathy, stroke, maker, dementia, chronic kidney disease and The most recent MDS was a quarterly assessment ment Reference Date) of it was coded as being bility to make daily life ent was coded as requiring extensive care for transfers, di hygiene; and limited chronic stances are reported cian | F | 342 | | | |
| | were made aware of | Executive Nurse (ASM #2) the concern. ASM #2 stated nary Report" is an internal | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 203 of 20



| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 | | A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED C 02/07/2019 | | | |
|--|--|--|---|--------------|---|---|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | Q | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD PROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 947 SS=E | document and is no record. At this time, legal clinical record regarding how this finjuries, and if there or revisions. No further information the survey. Required In-Service CFR(s): 483.95(g)(1) §483.95(g) Required aides. In-service training material service training material | t part of the legal clinical she was notified that the did not reflect the above data all occurred, if there were any were any care plan reviews on was provided by the end of Training for Nurse Aides ()-(4) I in-service training for nurse ust- fficient to ensure the ace of nurse aides, but must ours per year. The dementia management abuse prevention training. The sales of weakness as aides' performance reviews ent at § 483.70(e) and may needs of residents as cility staff. The sales providing services gnitive impairments, also | F 94 | 7 F947 1. | | ning , 8, 9 ng rent ve the ng nd or eduled | | |
| | This REQUIREMEN' by: Based on staff inten- review, it was determ provide the required | e of the cognitively impaired. MENT is not met as evidenced interview and facility document etermined the facility staff failed to sired annual in-service training's rtified nursing assistants) who | | 4. | Director of Nursing will au training monthly for 4 mon then randomly thereafter ensure required dementia training is occurring. Varia | nths to | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVE **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 947 Continued From page 204 F 947 were employed for at least one year. The facility staff failed to provide the required and brought to monthly Quality annual 12 hours and/or dementia management Assurance and Performance training's for CNA #1, CNA #2, CNA #3, CNA #4, Improvement Committee CNA #5, CNA #6, CNA #7, CNA #8, CNA #9, and monthly with QAPI committee CNA #10. responsible for ongoing The findings include: compliance. 5. Date of compliance: 3/15/19 On 2/6/19 at approximately 9:00 a.m., a request was made to administrative staff member (ASM) #2, the nurse executive, for the training transcripts, for all CNAs who were employed at the facility for at least one year. For six of the above listed CNAs, an "In-service Record" was provided. The following was documented: CNA #2 - last training's completed - 1/5/18 CNA # 3 - last training's completed - 1/5/18 CNA#1 - last training's completed - 1/8/18 CNA #6 - last training's completed - 1/5/18 CNA # 7 - last training's completed - 1/8/18 CNA#9 - last training's completed - 1/8/18. There were no training records for CNA #4, CNA #5, CNA #8 and CNA #10. An interview was conducted with RN (registered nurse) #5, the nurse practice educator, on 2/7/19 at 11:36 a.m. When asked if she had any other documentation of training's provided to the above listed CNAs, RN #5 stated, "I have reviewed all the files in my office and I haven't been able to find any other documented training's since RECEIVED

Event ID: Y30C11

January 2018."

ASM #1, the executive director, ASM #2 and ASM

MAR 0.8 22!9

PRINTED: 02/22/201

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | C C | | |
|--|---|---|---|-----|--|--------------------------------|----------------------------|--|
| | | 495246 | B. WING | | | | 02/07/2019 | |
| NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 | | | DDE | 02/0//2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE | |
| F 947 | #3, the clinical qual aware of the above p.m. | ge 205 ity specialist, were made concern on 2/7/19 at 3:46 on was provided prior to exit. | F | 947 | | | | |
| | | | | | | | | |

PRINTED: 02/22/201 **FORM APPROVE**

VDH (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING VA0279 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WOODMONT CENTER 11 DAIRY LANE FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 000 Initial Comments F 000 An unannounced biennial State Licensure Inspection was conducted 2/5/19 through 2/7/19. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 118 certified bed facility was 103 at the time of the survey. The survey sample consisted of 45 current resident reviews and 10 closed record reviews. See F-641 F 001 Non Compliance F 001 See F661 The facility was out of compliance with the following state licensure requirements: SeeF730 This RULE: is not met as evidenced by: See F732 12 VAC 5 - 371 - 250 A - cross references to Federal deficiency 641 See F622, F695 12 VAC 5 - 371 - 360 E 11 - cross references to See F622 Federal deficiency 661 See F676, F695 12 VAC 5 - 371 - 200 B 3 and B 9 - cross references to Federal deficiency 730 See F-656,695 12 VAC 5 - 371 - 210 D - cross references to See F622 Federal Deficiency 732 12VAC5-371-140. Policies and Procedures. See F580 Cross reference to F622, F695 See F684 12VAC5-371-150. Resident Rights. RECEIVED Cross reference to F622 See F695 12VAC5-371-220. Nursing Services. See F583 Cross reference to F676, F695 See F656 12VAC5-371-250. Resident Assessment and Care LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

FORM

If continuation sheet 1 of 2

PRINTED: 02/22/2011 FORM APPROVE

VDH (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING _ B. WING_ VA0279 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 001 Continued From Page 1 F 001 Planning. Cross reference to F656, F695 12VAC5-371-360. Clinical Records. Cross reference to F622 12VAC5-371-220. Nursing Services cross reference to F580. 12VAC5-371-220. Nursing Services cross reference to F684. 12VAC5-371-220. Nursing Services cross reference to F695. 12VAC5-371-150. (F) cross references with Federal deficiency 583 12 VAC 5-371-250 (G) cross references with Federal deficiency 656